Salish Behavioral Health Organization

Detailed Plan Response

October 2015

Contents

Section I: General and Overall Transition Plan 3
Section II: Transition and Coordination of Services Plan 7
Section II Subsection (i): Before Implementation 7
Section II Subsection (ii): After Implementation 7
Section III. Communications and Stakeholder Plan 9
Section III Subsection (i): Consumers 10
Section III Subsection (ii): Providers 16
Section III Subsection (iii): Advisory Board 16
Section III Subsection (iv): Stakeholders 17
Section III Subsection (v): Staff 18
Section IV: Network Analysis and Development Plan 19
Section IV Subsection (i): Network Analysis and Development Plan—Mental Health ... 19
Section IV Subsection (ii): Network Analysis and Development Plan—Substance Abuse 22
Section V: Staffing and Workforce Development Plan 33
Section V. Subsection (i) Training 33
Section V. Subsection (ii) Personnel 33
Section V. Subsection (iii) Ombuds 34
Section VI: Financial and Administrative Plan 35
Section VII: Utilization Management 41
Section VIII: Quality Assurance Plan 49
Section IX. Program Integrity Plan 61
Section X: Grievance System Plan 79
Section XI: Tribal Coordination and Communication Plan 103
Section XII: Evidenced Based, Research Based and Promising Practices Analysis and Development Plan 105
Section XIII: Behavioral Health Data Consolidation Project Plan 107

***Note: Exhibits referenced in this document are included in a separate binder labeled Exhibits. **The detailed plan question spreadsheet is at the end of this binder.**

Section I: General and Overall Transition Plan

The Peninsula Regional Support Network (PRSN), comprised of Kitsap, Jefferson and Clallam Counties in the Northwest corner of Washington State, was formed in 1989 as a result of 2SSB 5400, which encouraged Counties to join together to form Regional Support Networks. The PRSN has successfully managed the Mental Health system in its constituent counties for the last 25 years while navigating the change to managed care in 1994, integration of inpatient responsibility in 1996, adoption of the Balance Budget Act federal regulations pertaining to Prepaid Inpatient Health Plans in 2004, and the budget debacles of 2009– 2015. Due to our success in managing the system while minimizing administrative expenditures, the commissioners of the three constituent counties have made a decision to enter into a new Interlocal Agreement to form the Salish Behavioral Health Organization (SBHO). The draft Interlocal Agreement is attached as **Exhibit 31**.

The Interlocal Agreement will continue to designate Kitsap County as the administrative entity for the SBHO, and the SBHO will continue to be a program under Kitsap County's Human Services Department. This arrangement provides a number of benefits, of particular note in this case is that the Department has historically housed chemical dependency services and that staff is strongly involved in BHO development. Drug Court services are also managed by the Department, with Kitsap Recovery Center operated by the Department and providing outpatient drug court services. The Recovery Center also provides residential and Detox services, and will continue to be a contractor to the SBHO.

In addition to utilizing the expertise of existing Kitsap County staff during this transition, the PRSN/SBHO is leaning heavily on the Clallam County Health and Human Services Department to assist with clinical expertise and local contacts. The current plan going forward is to contract with Clallam County to provide clinical oversight under the SBHO.

It is our intention as we transition substance use disorder (SUD) services into a managed care service structure and delivery system to minimize disruption to the current system and maintain its structure to the greatest extent possible. We will offer contracts to all existing outpatient SUD providers currently providing publicly funded SUD services in our constituent counties. In this way we hope to minimize the impact that a system change of this magnitude might have on the service delivery structure and those we serve.

The SBHO will move the provider community to a case rate payment structure, and our intention is to build into those rates additional funding for individual services and case management, as these types of service have not been provided widely in the past and have the potential to support individuals on their path to recovery. We have contracted with an outside contractor to work with current SUD contractors in rate development, and draft rates will be developed by December of 2015.

Staff from the PRSN/SBHO have been meeting with current SUD contractors in our region since March of 2015, as well as county chemical dependency advisory boards, and have presented outlines of our intention to these groups on numerous occasions. We began

meeting individually with SUD providers in June, and have presented our pre-delegation evaluation tool to all potential providers.

Residential inpatient care for the SBHO will primarily be provided by the Kitsap Recovery Center (KRC) in Bremerton and Specialty Services in Port Angeles. The current plan for KRC is to shrink to a 16 bed program. Even with the loss of beds at KRC, the majority of adult residential needs will be met through these two programs. Access to beds in other regions will continue to be possible, and BHOs across the state are developing systems to allow for seamless access and payments to occur. Specialty residential services will occur outside the SBHO, though we continue to work with Specialty Services and the Division of Behavioral Health and Recovery to advocate for the development of a 16 bed youth residential program in Port Angeles.

The PRSN/SBHO will work with the therapeutic courts located in each county to ensure a smooth transition of drug court and CJTA services to BHO oversight. These services have not heretofore been subject to any significant utilization management or review, and the transition of these services may be one of the more difficult components of this change. We began meeting with Judges involved in Therapeutic Courts in September to discuss the upcoming changes and service structures that could continue to meet their needs while being defensible from a medical necessity and managed care perspective. Each of the constituent counties in the SBHO has passed the 1/10th sales tax, and one option that might be explored is for those funds to supplement BHO funds when Medical Necessity is not present for Therapeutic Court participants.

Opiate Substitution Treatment services are not widely available currently in our region, and we will be working with the medical community, SUD providers and MCOs to expand these services.

Information Services will be a critical area of development for the SBHO, particularly as the structure for reportage is not yet developed by the state. Historically, the PRSN has contracted with Kitsap Mental Health Services to manage our data collection and reporting, a situation which will change as we become a BHO. The SBHO will have a comprehensive data collection, analysis and reporting structure which all BHO contractors will feed data to through SFTP connections. Contracting mental health centers will have the option of reporting data themselves or contracting with Kitsap Mental Health Services to do so.

PRSN/SBHO staff are meeting with all SUD contractors to discern their current IS capabilities in order to craft a solution acceptable to all. It appears that data reporting is not an insurmountable issue, as many of the existing SUD providers utilize the same EMR which they use to transmit both HIPAA and TARGET data to the state. Contractors not on this system will be encouraged to purchase it, and SBHO staff will work with the service providers and their IS contractor to establish connectivity and synchronicity with the BHO system when it is established in February.

The Salish BHO intends to make this shift as painless and stress free for SUD providers and services recipients as possible, but that does not mean that changes will not be expected. Our rate and reimbursement structure will incentivize services that maximize recovery while ensuring providers rates that are supportive of their continuing existence. Our contracts will require robust integration between service providers and other health care practitioners, and our expectation will be that tight coordination of services is the norm. The Salish BHO will also have an information system that will allow us to track performance for all contractors in the same manner using similar data and performance standards.

The Peninsula RSN has a strong track record of compliance with federal regulations, and successful oversight of services, and it is our full intention to assist SUD providers through the transition to managed care and ensure that that track record continues as we become the Salish BHO.

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Section II: Transition and Coordination of Services Plan

Section II Subsection (i): Before Implementation

This section addresses **Question 245**—Information Requirements—Enrollees. The SBHO will use a number of mechanisms to notify individuals in treatment of the transition of their care prior to April 1, 2016. Most important will be clear communication with all service providers and others involved in the SUD treatment system (including therapeutic courts) regarding the change, and the intention of the SBHO to continue to provide funding for services to those currently enrolled through current service contractors. In addition to meeting with providers, courts and others, we will establish a webpage which will describe the change process and what people can expect going forward.

In December, we will begin formal communications by sending letters to providers with clear instructions for change-over, and provide our first written notification to individuals in treatment at transition. We will ask SUD providers to include an informational flyer in their intake packets beginning in January, and that they post the flyer in a conspicuous place. Individuals in treatment will receive mailings three times – late December, February, and March – outlining the change in contracting structure. All service recipient communication will be provided to DBHR for review, and will be targeted to a 6th grade reading level whenever possible.

The SBHO will enter into contracts with SUD treatment providers as early as possible after receiving a contract from DBHR, which will allow us to have providers include a release of information in intake packets allowing the SBHO to review treatment information. This will allow us to begin reviewing treatment episodes prior to go-live to evaluate the correct pro-rated case rates to assign to individuals in service at change-over.

Residential providers will be part of our communication plan during this transition process, and our intention is to continue to pay a daily rate for services for individuals in residential beds at change-over.

It is our intention that for individuals currently enrolled in services we will make payment for their services through service completion.

Section II Subsection (ii): After Implementation

Post Implementation coordination activities will focus on the experience of those in services in March of 2016, and ensuring that those with active services who had not completed services continue to be served. Our SUD contracts will include this as a requirement, and our first reviews, conducted in April of 2016, will include a review of performance on this requirement. We will review all of our contracted providers for the average monthly intakes and numbers enrolled over the last twelve months, and their

contracts will include expectations that these numbers remain consistent during change-over.

One of the additional positions which we will be creating is a Systems Development Manager to coordinate with referral sources throughout the Region. One of the expectations is that through clear communication referral patterns can remain intact.

Section III. Communications and Stakeholder Plan

The Salish Behavioral Health Organization (SBHO) is dedicated to open communications with the communities we serve, including consumers, family members, providers, and ancillary community providers. During the development process we have been in constant contact with our provider community, including providers of mental health as well as Substance Use Disorder services. We have accomplished this by attending provider meetings coordinated by County Chemical Dependency Coordinators, as well as meeting independently with SUD providers in all three constituent counties.

In addition to provider communications, the SBHO has regularly attended local Chemical Dependency Advisory Board meetings, as well as County 1/10th Sales Tax Committee meetings as they are available. Development information has been regularly shared with the PRSN Advisory Board, and the SBHO Board as it becomes operational.

During the development of the SBHO, significant effort will be put into contacting and coordinating with all of the critical allied systems that utilize and make referrals to the SUD treatment system. The SBHO will develop informational material which will be distributed in as broad a manner as possible, including distribution to allied system partners and county health and human services departments. The information will be posted on the PRSN and SBHO Websites and distributed to all advisory boards operational within the region.

SBHO Advisory Board (**Questions 47 and 151**)

The SBHO has established an advisory board which will be made up of seventeen members, with five members from each constituent county and two at-large tribal representatives. The board will be recruited widely, with members of the existing chemical dependency boards, 1/10th boards, and the PRSN Advisory Board invited to apply. The Executive Board has established a nominating committee made up of six members, one member from each county's chemical dependency board and one member from each county's delegation to the PRSN Advisory Board. The Nominating Committee will make appointment recommendations to the Executive Board with the intent of fulfilling the requirements for board makeup included in the Plan guidelines.

The SBHO Advisory Board will be relied upon to review program design, make funding recommendations, maintain citizen involvement in Quality Assurance and Quality Review Team activities, and review program performance. In the SBHO, it is our intention to maintain a Quality Review Team (QRT) in the same manner as has existed in the Peninsula Regional Support Network. The QRT is made up of volunteers from the advisory board as well as other interested community members, and this group along with pertinent staff and the Ombudsman review each contracted provider at least every other year. These reviews consist of meetings with ancillary providers in the contractors area, as well as meeting with key contractor staff. This review structure has allowed the PRSN to gain a deeper understanding of our contracted agencies, and to involve a broad array of individuals in this process. A copy of a recent QRT reports for three of our contracting agencies are attached under **Exhibit 25 (a-c)**.

In addition to consumer participation at the administrative level in various fashions, it has been and will be a foundation of the SBHO that consumers are closely involved in their own treatment planning and road to recovery. To this end, as part of our extensive clinical review process, we review the inclusion of individuals in their care planning and creation of their treatment regimen in our normal review of care. Examples of some of our clinical review tools can be found in **Exhibit 26 (a-d)**.

Section III Subsection (i): Consumers

The Salish Behavioral Health Organization (SBHO) has formally adopted policies and procedures to implement actions which ensure individuals eligible for behavioral health services are notified of the existence, availability, and scope of services within the SBHO. The SBHO regularly and consistently provides information that assists the enrollee's progress toward recovery and resiliency.

The SBHO shall provide to persons served by the Behavioral Health Organization (BHO) information on the following topics, through the Medicaid Benefits Booklet and SBHO produced materials:

- Access to Care
- Covered Title XIX and State Funded Services
- Consumer/Member Service Contact Information
- Provider Network
- Grievance, Appeals and Fair Hearings Rights
- Ombuds Program
- Consumer Rights
- Availability of written materials in alternative formats and how to access those formats

In addition to English, the SBHO shall provide the information described above in the following prevalent languages:

- Cambodian
- Chinese
- Korean
- Laotian
- Russian
- Spanish
- Vietnamese

The SBHO shall:

- Provide written materials in easily understood language and format, including alternative formats
- Post all materials on the SBHO Website
- Provide each individual authorized for care with a consumer handbook
- Post client rights at each provider site in the languages set forth above
- Provide access to written interpretation of all consumer materials
- Provide access to these materials prior to conducting an intake evaluation

The SBHO will provide annual training to providers, subcontractors and local NAMI organizations on the efforts to provide general information to enrollees in the region. This will include, but is not limited to the availability of behavioral health services, how to access and request information and how to exercise their rights.

The SBHO monitors network compliance, efficiency and effectiveness regarding the general information requirements through annual SBHO Provider and Subcontractor Administrative Review, regular Quality Review Team (QRT) site visits, grievance tracking and reporting and monthly Ombuds reports to the Quality Improvement Committee (QUIC). If a provider performs below expected standards as identified through the reviews and reports listed above, a Corrective Action will be required.

The PRSN Comprehensive Information Plan will be updated and included in the Policies of the SBHO. The current plan is attached as **Exhibit 27**. The PRSN Member Handbook is attached as **Exhibit 28**, and will be updated in much the same form for the SBHO.

The SBHO policy and procedures on General Information and the Information Plan for SBHO Delivery System and Services addresses the dissemination of general information materials to consumers. The SBHO is committed to implementing policies and procedures along with the comprehensive information plan that includes benefit information, services available, how to access services, enrollee rights and responsibilities. The policies and procedures as well as the information plan include accommodations available for diverse populations within the region, inclusive of languages other than English. The SBHO, network providers and subcontractors will incorporate the use of media, stigma reduction activities, and strategize to conduct ongoing evaluation of the strategic information plan.

The state Health Care Authority (HCA) provides all enrollees with the Medicaid benefits booklet. This booklet is a resource that provides enrollees with information regarding their rights, benefits and responsibilities. It is also available on the Internet at the Division of Behavioral Health and Recovery website. The SBHO has designed a brochure and member handbook that include information about the SBHO, a description of services and how to access them, provider locations and contact information, Ombuds information and how to file a grievance at either the agency or SBHO level.

An enrollee of the SBHO has the right to receive information in accordance with CFR Section 438.10. The SBHO complies with any and all applicable federal and state laws and regulations that pertain to enrollee rights. All persons who seek services from the SBHO and its network providers are entitled to be addressed and treated with respect and dignity consistent with the enrollee rights listed in the state Medicaid benefits booklet.

The SBHO and network providers furnish information to potential enrollees by disseminating materials at a broad array of locations accessed regularly by individuals who may qualify for services. Providers make this information available prior to and during the intake process. Provider brochures, along with SBHO and Ombuds brochures, are located in publicly accessible areas within provider facilities, disseminated to local NAMI organizations, and made available to local family Al-Anon and Nar-Anon groups. The SBHO and network providers are listed in area telephone directories and resource directories utilized by allied service providers.

Alternate Formats

Enrollee informational materials are available in alternative formats for enrollees who are blind or sight impaired, and are translated into the seven prevalent languages identified by DSHS. The SBHO also relies on the State Office of Deaf and Hard of Hearing at https://www.dshs.wa.gov/altsa/office-deaf-and-hard-hearing for additional assistance with video-relay and other telecommunications needs. The SBHO network providers and subcontractors are required to provide interpreter services for enrollees with a primary language other than English for all interactions between the individual and the provider or subcontractor. The SBHO keeps network providers and subcontractors informed as to how to access oral interpreter services including the Language Line which the SBHO has a master contract with which is utilized by all contracted providers. When needed, network providers and subcontractors engage qualified language translators that have been screened by the state. American Sign Language interpreters are available as needed.

The SBHO ensures enrollee rights are posted at network provider locations in all seven DSHS target languages. The SBHO furnishes translated materials on access to care, Medicaid and non-Medicaid covered services, provider contact information, Ombuds contact information, SBHO contact information, and consumer rights. Information on how to receive written material in an alternative language must be provided to the individual prior to conducting an intake assessment.

The SBHO monitors contractor compliance to ensure free oral interpretation and sign interpretation services are available to enrollees.

In accordance with the PRSN Notification of Primary Mental Health Care Provider Termination policy, and network subcontracts, which will be included in the SBHO policies, when a health care provider (HCP) is terminated the agency must make a best effort to provide written or oral notification within fifteen working days of the termination to Medicaid enrollees currently opened for service or who have received service from the individual care provider within the previous sixty days.

1. A copy of the HCP termination notification must be placed in the enrollees medical chart.

2. If verbal notification is provided, there must be a legible chart note documenting the verbal notification.
    - This clause is included in each of the network provider subcontracts.

Notification to enrollees about a terminated CMHA, SUDA or HCP includes information about available network providers and steps to ensure a coordinated transition of care to an alternative agency or provider.

Terminated CMHA or SUDA
For a terminated network CMHA or SUDA, the SBHO will provide written notification to a member that includes the name and location of the of the terminated network CMHA or SUDA, the termination effective date, alternate service providers and their locations, steps that the SBHO will take to coordinate and transfer care to an alternative provider, crisis line number, and contact numbers for assisting member with questions, to include the SBHO office, the SBHO Ombuds, and Division of Behavioral Health and Recovery.

The SBHO will provide notification for the following systems within the required timeframes:

- The SBHO will immediately provide verbal and written notification to the Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) of the termination status, at a minimum thirty days prior to the termination date.
- The SBHO will provide notification to the local Community Service Office (CSO) within at least ten days prior to the termination date.
- The SBHO will provide notification to the allied service providers in the CMHA or SUDA area within at least ten days prior to the termination date.

In addition to directly notifying the enrollee, the DBHR, CSO, and the local allied systems the SBHO will conduct the following activities at least ten days prior to the termination date:

- Post the notification on the SBHO webpage
- Publish the notification in the local newspaper(s)
- If available, provide notification on the local public access television channel
- Verbally announced on local radio stations

The Salish BHO will communicate with consumers whenever an action is taken regarding their care, as defined in CFR. The SBHO will modify the PRSN policy titled Notice of Action Notification, and will issue a Notice of Action (NOA) written notification to Title XIX enrollees when the SBHO (or the subcontracted administrative service office delegated to conduct the PIHP authorization functions) makes any of the following authorization decisions related to outpatient, inpatient, or residential services:

- Deny authorization for requested and covered Medicaid behavioral health services that meet medical necessity criteria and Access to Care Standards
- Deny an intake assessment
- Limit previously authorized services, including the type or level of service
- Reduce previously authorized services
- Suspend previously authorized services
- Terminate previously authorized service
- Denial of payment, in whole or part, for a service
- Failure to authorize and provide services within the required timeframes, considered a denial and subject to an appeal

The SBHO written NOA letter includes the following information:

1. A statement of what action the SBHO, or the subcontractor, intends to take
2. Reasons and basis for the intended action
3. An explanation of the enrollee's right to request an appeal, or a state administrative hearing, and the procedures for exercising these rights under WAC 388-865-0410
4. The circumstances under which expedited resolution is available and how to request it
5. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services
6. The DBHR definitions of reduction, termination, suspension and denial

Reviews of all psychiatric inpatient service denials are done by a licensed, board-certified psychiatrist, while reviews of any denial for SUD services is accomplished by a Chemical Dependency Professional or a Doctor of Addiction Medicine.

The SBHO NOA notice is in writing and meets the language and format requirements of 42 CFR 438.10 (c &d), including but not limited to ease of reading. The SBHO NOA written notice is provided in the easily understood primary language of the enrollee, available in alternative formats that take into consideration the special needs of those who are, for example, visually limited or have limited reading proficiency. The SBHO uses the template NOA provided by the Division of Behavioral health and Recovery (DBHR), inserting local contact information and case specifics prior to issuing the letter.

The SBHO issues standard NOAs through the mail and has the ability to fax an NOA immediately or as expeditiously as the enrollee's health condition requires. In addition, the policy outlines the verbal notification procedures. The SBHO issues an NOA written notification according to the following timeframes:

- For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten days before the effective date of the action except if the criteria noted in 42 CFR 431.211, 431.213, or 431.214 are met.

- For denial of payment, at the time of any action affecting the payment.
- For standard service authorization decisions that deny or limit services, as expeditiously as the enrollee's health condition requires and no longer than fourteen days from request for service except in circumstances for possible extension of this timeframe as noted in 42 CFR 438.210 (d). Under circumstances that would benefit an enrollee up to an fourteen additional days are possible.

SBHO Letter of Ineligibility

As stated in the Salish Behavioral Health Organization (SBHO) policy titled Service Denial Authorization Decisions and Notification, the SBHO issues a letter of ineligibility as a written notification to Title XIX enrollees when the individual requesting outpatient services does not meet the Access to Care Standards.

The SBHO letter of ineligibility notification letter includes the following information:

- Reason and/or clinical basis for the decision in clear and understandable terms.
- The right to request a second opinion regarding the outpatient assessment and how to request the second opinion.
- Reference to the service provision, clinical criteria, guideline, protocol, and/or statue.
- Local Ombuds contact information to assist understanding and filing an appeal.
- Referral information to local services.

SBHO Grievance and Appeals Process

When the SBHO issues a Notice of Action to a Title XIX enrollee, information about the SBHO Grievance and Appeal processes are included in the SBHO Notice. The SBHO policy titled Service Denial Authorization Decisions and Notification outlines the following Grievance and Appeal information:

1. The SBHO has a standardized system in place for enrollees that includes a grievance process, an appeal process, and access to the State's administrative hearing system.
2. The SBHO grievance system is consistently applied throughout the entire service area.
3. An enrollee may have a representative, or advocate, who acts on his or her behalf in filing and pursuing grievances, appeals and administrative hearings.
4. Specific timeframes for the filing of grievances and appeals, including the SBHOs timelines for response.

Ombuds Office **(Question 175)**
PRSN/SBHO currently contracts with the Dispute Resolution Center (DRC) for mental health ombuds services. SBHO plans to continue this contract with DRC, but will require DRC to hire an additional staff member to handle the anticipated increase in volume of cases. Both DRC ombuds staff will handle mental health and chemical dependency referrals.

Section III Subsection (ii): Providers

During the development of the Salish Behavioral Health Organization, efforts have been made to meet with currently contracted SUD providers in our region as frequently as possible to maintain open dialog and communications. Staff of the future Salish BHO have attended meetings called by county chemical dependency coordinators and are meeting individually with providers as needed. Efforts have been made to gather input from the provider community regarding the proposed rates structure and impact of Information Services changes on them. Providers have been of great assistance in guiding the efforts of the SBHO as it develops.

As the Peninsula RSN, we have instituted monthly provider meetings with our core provider network, and it is anticipated that monthly meetings will continue with all providers going into the future. Providers will be asked if they prefer to have more localized meetings due to travel constraints, or to have region wide meetings. Following initial implementation, frequency of meetings may be reduced to bi-monthly or quarterly over time. It is anticipated that SUD providers will need significant assistance from the SBHO in the initial stages of implementation, and it is planned that SBHO staff will be available on an as needed basis to assist any provider. During the development time period, SBHO staff have met individually with SUD providers to assist their understanding of the changes taking place, as well as to educate ourselves about SUD services in general and the provider network we will be working with.

Providers will be invited to all Advisory Board and Executive Board meetings, and the SBHO will maintain a strong presence on the Internet, posting as much information as possible on a timely basis. The Peninsula Regional Support Network had a very robust presence on the Internet, and it is anticipated that that will continue to be the case as the Salish BHO.

Section III Subsection (iii): Advisory Board

Staff from the Peninsula Regional Support Network have met with substance use disorder and county sales tax boards repeatedly during the development of the Salish Behavioral Health Organization, and will continue to meet with them as invited.

The Salish BHO has begun recruitment for its advisory board, with the first review of applications taking place in September of 2015. Initial recruitment was as broad based as

possible, with existing advisory board members from the Regional Support Network, county chemical dependency boards, and county sales tax boards all invited to apply. Both community mental health centers and substance use disorder providers were asked to recruit members, and the availability to apply was advertised in local papers and on the PRSN and SBHO web sites.

The Executive Board of the SBHO has agreed to an expanded makeup of the SBHO Advisory Board, including two at – large seats for individuals representing Native Americans. The SBHO has the fortune of having seven Tribes within its borders, and all seven Tribes have been asked to nominate representatives to the Board.

Meetings of the Salish BHO Advisory Board will take place at least quarterly, and will probably occur monthly for the first year during the initial change over to managed care for the SUD system. Providers are not eligible to be Board members under the SBHO Interlocal Agreement, but are invited to all Board meetings and will be integral to the education and edification of the new Advisory Board.

Section III Subsection (iv): Stakeholders

As outlined previously, in the development of the Salish BHO, significant efforts have been made to reach out to providers and community members who have an interest in the Substance Use Disorder field and the services available to the people of the Peninsulas. These efforts will continue, as all three counties are interested in better aligning their local Treatment Sales Tax efforts with those of the BHO. One area not previously addressed for communications is the interface with treatment courts, of which there are fourteen in the three counties of the SBHO. We will begin reaching out to treatment courts in October of 2015 and continue to work with the courts for the duration of implementation and beyond. It is or intention to integrate the justice system into the treatment system as seamlessly as possible while maintaining strict standards for medical necessity.

During the lead up to April 2016, the SBHO will work with county human services departments to utilize their mailing lists to fully inform local communities as to the changes taking place, and what to expect going forward. These efforts will begin no later than November and continue through March of 2016. As stated previously, the Salish Behavioral Health Organization website is already live, and will be updated on a regular basis to inform the broader community of the changes taking place.

Agreements with City and County Jails (**Question 174**).
Sample agreements between PRSN agreements, jails and providers is included as **Exhibit 46**. SBHO is working to update those agreements that are due for renewal.

Section III Subsection (v): Staff

Staff of the Peninsula Regional Support Network have been involved in the development of the SBHO on a daily basis, and will continue to be involved on an ongoing basis. Staff from constituent counties involved in health and human services programs have been involved on an ongoing basis, and it is the current plan for the SBHO to subcontract with Clallam County for some level of support for the immediate future.

During the development of the SBHO, outreach has taken place to all SUD providers in the Region, but aside from posting as much information as possible to the SBHO website, it is not really possible to guarantee that all SUD provider staff are fully informed and up to date. Some agencies have included a number of their staff in their individual meetings with PRSN staff during the development process, and PRSN/SBHO staff will offer to attend and present at all-staff meetings or to agency boards if requested.

Section IV: Network Analysis and Development Plan

SBHO will have a comprehensive network of mental health and substance use disorder (SUD) treatment providers. The mental health provider system in the Peninsula region is well established, offering a wide variety of inpatient, outpatient, and residential mental health services. Over the past several months, PRSN/SBHO has been collaborating with SUD providers, courts, and other stakeholders toward the goal of a treatment network that can meet the current and future needs of those in need of SUD treatment in our region.

The following sections describe current efforts and plans to address network analysis and development for mental health and substance use disorder treatment within SBHO.

Section IV Subsection (i): Network Analysis and Development Plan—Mental Health

Current System

For the past several years, PRSN has had a stable network of mental health providers that have been able to meet DBHR contract requirements. PRSN has been able to meet network sufficiency requirements, including time and distance standards. On the rare occasion when a network provider was unable to provide a contractually required service, the provider used PRSN funds to purchase the services elsewhere.

PRSN currently contracts with four main community mental health agencies:

Kitsap County:

- Kitsap Mental Health Services
    - Outpatient
    - Crisis
    - Residential
    - Evaluation and Treatment Center

Clallam County:

- Peninsula Behavioral Health
    - Outpatient
    - Crisis
    - Residential
- West End Outreach Services
    - Outpatient
    - Crisis

Jefferson County:

- Jefferson Mental Health Services
    - Outpatient
    - Crisis

Assessment and Plan

PRSN assesses network sufficiency of mental health services on an ongoing basis through review of utilization management data. PRSN provides feedback to agencies, the advisory board, and the executive board on concerns regarding patterns around the number and types of services provided to consumers, and how this information fits into the overall treatment capacity of the network.

At the RSN level, there is currently no indication of a need to increase the number of mental health agencies due to capacity. At the provider level, there are ongoing concerns about the ability to find staff to deal with the increase in enrollees due to Medicaid expansion. Provider agencies are working on expanding their recruitment efforts.

In the past year, PRSN has worked to increase specific services to address the use of crisis and inpatient care as well as the number of consumers incarcerated. Recent efforts include:

- Plans to open a crisis triage center in Kitsap County (in process)
- A new crisis bed unit in Clallam County (in operation)
- Addition of a second PACT team in Kitsap County (in operation)

These represent an increase in type and intensity of services provided in our region.

Plan: Mental Health Network

SBHO will contract with the agencies listed above for existing services and will continue to monitor network adequacy. Under guidance from the SBHO advisory and executive boards, SBHO will continue to explore options for incentivizing effective, outcome based services in our region.

Coordination with CLIP Administration (**Question 231**)

The PRSN actively participates in the care management of youth detained and subsequently placed under all legal holds and especially 180 day commitment orders by brokering with clinical staff, family members, natural and community supports to assertively exhaust all lesser restrictive options while sufficiently addressing safety needs of the youth and family. Through clinical consultation, file review and conducting child and family team meetings, determining the need for long term inpatient utilization is a collaborative and comprehensive process that attends to each child/families individual needs. Brokering with natural and community supports in addition to ancillary professional providers, robust efforts take place to attempt to maintain children in their home and community.

The PRSN Children's Care Coordinator consistently participates in pre-admit meetings, treatment review and discharge meetings at each corresponding CLIP facility where a child is served.

The PRSN participates in quarterly meetings with CLIP Administration to address utilization management, capacity, waitlists, clinical concerns and length of stays. The

PRSN Children's Care Coordinator has actively provided input to the CLIP Improvement Team and has assisted in reducing authorizations from one year to six months, enhancing parent voice in treatment and establishing pre-admit meetings.

The PRSN has consistently demonstrated effective collaborations and communication with families and allied system partners and is supported through adoption and implementation of Policies 12.06, 12.02. 12.09. and 12.09a included in this detailed plan as **Exhibits 41**, **42**, and **45 (a, b)**, respectively.

WISe Expansion (**Question 158**)

(1)The PRSN has a long history of providing intensive services to children while brokering with multiple systems to collaboratively and creatively address the unique individual needs of children and their families while integrating strengths, client voice and community/natural supports into mental health treatment. Requiring child/family team meetings as a regular component of this level of care is the essential element to coordinate care, empower clients and broker all necessary support to assist in achieving recovery. This historical foundation will allow for adoption of formal WISe services rather seamlessly. Currently this level of care is classified as Children's Intensive Services (CIS) in the PRSN, and reflects a child's involvement in two or more additional formal child serving systems including: Children's Administration, Juvenile Justice, Substance Abuse treatment, Developmental Disabilities Administration and Special Education. Having been placed in inpatient treatment facility and/or needing support of Crisis Intervention are factors that warrant potential provision of CIS. The PRSN has worked diligently to inform all ancillary system partners of the future of WISe services being developed in our region.

Rolling out WISe services across our three county region will occur in several stages with Kitsap County being first to deliver these services.

The PRSN has been directly working with Kitsap Mental Health Services (KMHS) our sole provider for Kitsap County, for several years in planning for WISe implementation. Participating in the original CANS (Child/Adolescent Assessment of Needs &Strengths) and WISe manual workgroups, KMHS has proactively worked to prepare their network adequately. Incorporating the CANS algorithm into our electronic medical record (EMR) has been completed. Working collaboratively with KMHS, a plan has been developed to educate the community, inform staff and refine eligibility criteria including using an algorithm to clearly identify and flag potential WISe recipients. The PRSN has sought out expert Wraparound training to fortify network of providers and prepare for WISe services in our region. Currently, KMHS is working actively on our plan to secure new work space for WISe teams, recruit staff, and implement a training plan in conjunction with PRSN and DBHR.

(2) On April 1, 2016 the PRSN will formally become Salish Behavioral Health Organization (SBHO) and be prepared to deliver WISe services to the Medicaid population of children in Kitsap County that meet access to care standards, implement the CANS algorithm and willfully agree to the provision of WISe services. The expansion document (Exhibit G)

forecasts the same number of WISe enrollees as established for January 1, 2017: 70 and therefore the plan remains the same.

(3) Potentially adopting one more additional team with capacity to serve ten more individuals, the plan for SBHO to meet the this capacity goal simply requires the addition of one more single team and will be achieved efficiently by continuing and bolstering the same planning efforts described above to achieve this goal.

The SBHO will develop specific policies and procedures that adequately address all provisions in the PIHP contract and WISe manual.

Coordination of Intensive community supports (**Question 234**)
The PRSN actively participates in the coordination of care for children and youth who demonstrate the need for intensive mental health services. Identified at intake, during reauthorization period or any time meeting the criteria of having multi-system involvement, previous inpatient utilization or serious safety concerns, children are placed in appropriate level of care; this population is given a subsequent flag of Children's Intensive Services (CIS) that allows for active management and oversight of services. Having access to each clinical record allows for clinical review and subsequent monitoring/implementation of any needed corrective action to sufficiently address each individuals needs helps ensure that adequate services are being provided.

PRSN utilization management procedures employ immediate notification when a child is admitted to any hospital or Evaluation & Treatment facility, which in turn allows for efficient exploration of lesser restrictive options and begins the discharge planning process.

Coordination of care is consistently supported by policies around coordination, for example 12.02 (**Exhibit 42**) and 12.06 (**Exhibit 41**), as well as chart reviews (tools included in **Exhibit 26**)

Section IV Subsection (ii): Network Analysis and Development Plan—Substance Abuse

The following section as a whole addresses **Question 19 (1)**. Comprehensive Program of Treatment: "Describe your system of care for substance use disorder treatment..."

In addition to a general introduction to the SBHO's planned system of care for substance abuse treatment, this section is also meant to address **Question 273 (1)**, Delivery Network: "Provide a detailed analysis of your delivery network..."

SBHO will have an extensive network of chemical dependency service providers. With the exception of one provider who elected not to contract with SBHO, the BHO will contract with all substance abuse treatment providers currently providing services through county based substance abuse contracts. All services will be provided through contracts with

licensed chemical dependency treatment agencies. Written agreements will be developed with other systems and ancillary providers as described below.

Analysis of Current Needs

The following factors were considered in determining the current and future needs of the substance abuse treatment system in the SBHO region.

Current Plans and Analyses

Interviews with the current county chemical dependency coordinators and a review of each county's current strategic plan indicated the following common concerns regarding substance abuse treatment in our region:

- Lack of adequate medical detox services
- Need for triage services for law enforcement to use as alternatives to incarceration
- Lack of local opiate substitution providers
- Need for more adolescent residential treatment
- Need for improved technology resources to address electronic medical record and reporting needs

SBHO will work closely with Kitsap Recovery Center and Kitsap Human Services to continue development of a crisis triage center in Kitsap County funded by local tax and RSN/BHO dollars. The triage center is expected to serve individuals with both mental health and substance use issues. Because the triage center will be co-located with the current detox center in Bremerton, long term strategies include upgrading staffing plans to allow for medical detox on site.

To address the lack of opiate substitution providers, SBHO will work closely with local government officials, community stakeholders, and the local hospital and physician network to develop and encourage a more robust opiate substitution network.

Regarding the need for increased access to adolescent residential treatment, SBHO is engaging in ongoing conversation with Specialty Services, a residential substance abuse provider in Port Angeles. Specialty Services has expressed an interest in providing adolescent residential treatment, should the state succeed in obtaining an IMD waiver for substance abuse treatment.

SBHO staff are having ongoing discussions with substance use disorder providers around electronic medical record and reporting requirements. SBHO will continue to provide technical assistance up to and after becoming a BHO.

Medicaid Enrollment and Expected Utilization

SBHO's region includes 76,000 Medicaid enrollees. Current utilization of substance abuse treatment indicates over 3,000 individuals served per year. Similar to our mental health providers, substance abuse agencies in our region have experienced an increase in the number of individuals seeking treatment since Medicaid expansion last year. However, a survey of SBHO's anticipated providers indicated that they were not turning away

consumers due to lack of treatment capacity. In fact, the majority indicated that they were capable of expanding the number of served individuals as needed.

Provider Requirements and Capacity

Exhibit 1, List of Planned Substance Abuse Disorder Treatment Providers is a list of providers that SBHO plans to contract with for substance abuse treatment. Results of a provider survey and discussions with current county chemical dependency managers indicate that most providers are able and willing to expand the number of individuals they serve. No providers indicated a waitlist or turning individuals away due to capacity.

Time and Distance Standards

SBHO will fund services across a wide geographic area, including urban, rural, and large frontier areas. The locations of the providers that SBHO plans to contract with for substance use disorder treatment will allow SBHO to be compliant with contract requirements. These agencies are in the same areas as our current mental health providers, and a previous GIS study indicated that we were able to meet DSHS time and distance standards.

Culture and Language Considerations

Cultural and language considerations for this region include:

- Seven tribes across the three county region
- A significant population of individuals whose first language is Spanish.

SBHO will continue to meet regularly with Tribal behavioral health staff and has agreements in place with each tribe in our region. SBHO will require agencies to provide culturally relevant services and use the Language Line when helping individuals whose primary language is not English. SBHO requires specialist consultations when clinically indicated.

Summary of System Analysis

The system described herein is sufficient to provide the services covered under the draft contracts, with the exception of those services not available in the SBHO region at this time. For those services, SBHO will purchase services from out-of-network resources, including:

- Medical detox—from out of region resources until available locally.
- Adolescent and Pregnant and Parenting Women residential treatment—from out of region resources or until available locally.
- Medication assisted treatment—through coordination with local physicians who provide this services and from out of region resources until available locally.

Planned System of Care for Substance Abuse Treatment

Attached as **Exhibit 1** is the list of SBHO's anticipated network agencies and the services they will provide. A more detailed description of these services is provided in the Planned

Continuum of Care section, below. This attachment and the narrative below are meant to meet the requirements of **Question 287 and Question 273 (2).**

The SBHO system of care for substance use disorder treatment will include providers across three counties, to include eight in Kitsap County, eleven in Clallam County, and one in Jefferson County. Details include whether these services are provided to youth, adults, or pregnant and parenting women. All services will be provided based on a DSM 5 substance use disorder diagnosis and ASAM placement following an assessment by a CDP.

The levels and types of treatment provided are described in detail, below. For specifics on levels of care, see Section VII: Utilization Management Plan.

Level 1 Outpatient Services and Level 2.1 Intensive Outpatient
Most of the agencies that SBHO will contract with for substance use disorder treatment will provide outpatient treatment and intensive outpatient treatment. Of those:

- Ten will provide these to adults, seven to adolescents.
- Nine providers will provide services to pregnant or parenting women. Two agencies have specialized expertise in the provision of SUD services for women who are pregnant.
- Three agencies use manualized, evidence-based chemical dependency treatment services for offenders.
- Six can address the needs of individuals who have either been referred through the Department of Corrections, Drug Courts or identified through activities funded by the Criminal Justice Treatment Account.

All agencies contracted to provide Level 1 (Outpatient) and 2.1 (Intensive Outpatient) services will be required to offer the following when medically necessary:

- Alcohol/Drug Screening and Brief Intervention as described in section 15.4.1 of the draft PIHP contract.
- Chemical Dependency Treatment as described in section 15.4.3(A) of the draft PIHP contract.
- Case Management Services as described in section 15.4.5 of the draft PIHP contract.

Some outpatient agencies will also provide or contract for Lab Services as defined in 15.4.4 of the draft PIHP contract. Others will use local laboratory providers.

Residential Services
The following providers in SBHO's region are able to provide residential services.

- Level 3.1 Clinically Managed, Low Intensity Residential Services: Recovery House Services. There are currently no contracted providers in the SBHO region for this service. SBHO will work with other BHOs to develop this resource.
- Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential services: Pioneer Center North

- Level 3.5 Clinical Managed, Medium Intensity Residential Services: Kitsap Recovery Center (Bremerton) and Specialty Services (Port Angeles)

Withdrawal Management
Two providers, Kitsap Recovery Center in Bremerton, and Specialty Services in Port Angeles, are able to provide withdrawal management services. These agencies will provide Inpatient Withdrawal Management (Alcohol and Drug Detoxification) as described in section 15.4.2 of the draft PIHP contract.

Ambulatory withdrawal management as described in section 6.1.1.5 of the draft BHSC contract will be provided through coordination between contracted outpatient providers and physicians in the community who provide this service. SBHO will work to increase the network of physicians willing to provide withdrawal management treatment.

Laboratory Services
When medically necessary, some of the outpatient, residential, and withdrawal management agencies listed in **Exhibit 1** will also provide or contract for Lab Services as defined in 15.4.4 of the draft PIHP contract.

Medication Assisted Treatment (**Question 50**)
No contracted agencies within the region currently provide medication assisted treatment. SBHO will work with local government entities, providers, and local physician networks (including hospitals) to encourage the development of this resource locally. Some non-contracted physicians in our region do provide this service. One large medical provider group in the region recently indicated that they plan to apply for a grant that would help in the development of MAT services.

SBHO will require contracted providers to engage in coordination of care with physicians or other out of network agencies providing this service.

Addressing Emerging SUD Challenges (e.g. new trends in opiate, meth, THC use and treatment (**Question 19 (3)**)
In order to address emerging substance use disorder challenges, including new trends in substance use and treatment, SBHO will:

- Communicate and coordinate regularly with local prevention organizations
- Fund training of providers and SBHO staff on the newest trends and treatment approaches
- Utilize data to analyze trends in diagnosis patterns
- Receive regular anecdotal feedback from providers on substance use trends in the community

Based on data trends and feedback from providers and the community, SBHO will adjust training and network development efforts as needed.

Services Provided Under the CJTA

SBHO will contract with the providers indicated in **Exhibit 1** for services under the CJTA contract. Treatment provided to individuals under the CJTA contract will be based upon assessment by a CDP and ASAM placement, following SBHO Substance Abuse Level of Care Guidelines. SBHO is currently meeting with judicial staff to discuss this process.

CD Involuntary Commitment (**Question 27**)

Involuntary commitment services are provided by a designated CD specialist. Currently, each county in our region contracts with an agency to provide these services. These specialists are designated by local county officials. After April 1, 2016, SBHO will designate these individuals. SBHO will contract with the following agencies to provide involuntary chemical dependency treatment evaluations:

- Kitsap County: Kitsap Recovery Center
- Clallam County: Reflections Counseling
- Jefferson County: Jefferson Mental Health Services

SBHO uses the following facilities when detaining an individual under the CD involuntary commitment statute:

- Pioneer Center North
- Kitsap Recovery Center

The involuntary commitment process is initiated when a referral is made to the Designated CD Specialist. The Specialist provides an assessment of the individual and if detention criteria are met, files a petition with the local court. At the same time, the petitioner contacts the inpatient facility (Pioneer Center North or Kitsap Recovery Center) and begins the referral process. If the local court is willing to hear involuntary commitment cases, the hearing will occur within 3-5 days. If the court approves the petition, the individual will be placed on the waitlist for the approved facility. Kitsap Recovery Center is licensed to provide services under the chemical dependency involuntary treatment act, but the facility is not locked and therefore is limited in which individuals it can accept.

Discussion with county chemical dependency managers revealed that there are currently no agreements that address this process. SBHO anticipates that there will need to be agreements developed with the local courts of each county in the SBHO region.

Evaluations by Designated CD Specialists—Notifications (**Question 29**)

SBHO will require designated chemical dependency specialists to perform the evaluations and notifications described in RCW 70.96A.142. PRSN/SBHO already requires similar notification processes through the mental health provider system. SBHO will modify existing policies on DOC notification to include the requirements in RCW 70.96A.142 for contracted chemical dependency providers.

SBHO will monitor this process through annual chart reviews and through communication and training of CD involuntary treatment providers.

Discussion with county chemical dependency managers revealed that there are currently no agreements that address this process. SBHO anticipates that there will need to be agreements developed with the local DOC offices in each county in the SBHO region.

Voluntary Treatment of Individuals with a Substance Use Disorder (**Question 25**)

The statute requires the following:

- RCW 70.96A.110(1): That individuals may apply for voluntary treatment directly to an approved program.
- RCW 70.96A.110(2): If a person is refused admission, they are referred to another approved treatment program.
- RCW 70.96A.110(3): That individuals leaving inpatient care are encouraged to consent to and are given help accessing appropriate outpatient treatment.
- RCW 70.96A.110(4): Individuals leaving treatment are given help obtaining shelter and transportation. Minors or those incompetent are discharged at the request of the legal representative or parent/guardian.

SBHO will require agencies to comply with these requirements through policy. In addition, SBHO will perform chart and/or administrative reviews of any agencies in the SBHO region that contract with SBHO to provide these services.

Treatment Program and Facilities—Peace Officer Duties (**Question 26**)

RCW 70.96A.120 allows a peace office or county designated staff to take an individual incapacitated or gravely disabled due to drugs or alcohol into protective custody for up to eight hours. The statute includes the following requirements:

- The individual can be taken to an approved treatment program or an emergency department. The individual may also voluntarily agree to be taken to the program or the emergency department.
- Once the individual is at the approved treatment program, they must be examined by a qualified person. If necessary, the approved program will refer the person to another program or for necessary medical care and arrange for transportation.
- A person may be detained for up to 72 hours if they meet the requirements of the statute.
- If the person is discharged without being admitted or referred to another facility, the facility shall provide the individual assistance in accessing shelter resources.
- If the person is admitted to the approved treatment program, the person's family or next of kin are notified as soon as possible, unless the person is an adult and requests that no notification be given.

Regarding those requirements that involve the facility (approved treatment program):

- SBHO will require agencies to comply with these requirements through policy. In addition, SBHO will perform chart and/or administrative reviews of any agencies in the SBHO region that contract with SBHO to provide these services.

Regarding those requirements that involve county designated staff:

- SBHO will require Designated Chemical Dependency Professionals to comply with these requirements through policy. In addition, SBHO will perform clinical chart and/or administrative reviews of services provided by Designated Chemical Dependency Professionals.

SBHO does not have the authority to require compliance with those sections of the statute that speak to the duties of peace officers or emergency departments but will monitor the implementation of the requirements by these entities.

Primary Care and Coordination of Health Care Services (**Question 280**)

PRSN/SBHO addresses coordination of health care services through administrative agreements, contract and policy requirements, and clinical chart reviews. SBHO will take the following steps to ensure compliance with the CFR, PIHP contract, and good practice:

- Referral to PCP: PRSN currently requires all mental health providers to refer consumers to a PCP at intake when they do not already have one. SBHO will apply this same requirement to substance use disorder providers through contract and updated policies.
- Coordination with MCO: PRSN has MOUs with Apple Health MCOs that cover individuals in our region. SBHO will update the MOUs to include those individuals receiving treatment for substance use disorder. We plan to work with willing MCOs to create a performance improvement project targeting high needs patients and ensuring better coordination of their care.
- Share with the MCOs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities: SBHO is working with the plans to develop better coordination and identification strategies around common, high need individuals. SBHO has contracted with IT developers, and hired new IT staff, to improve our database system.
- Other requirements: PRSN requires providers, when clinically indicated, to coordinate with the individual's primary care provider when the individual has medical issues. SBHO will extend this requirement to contracted substance use disorder treatment providers.

Delivery Network Documentation (**Question 273 (3) AND Question 279**)

SBHO is prepared to submit documentation demonstrating network sufficiency to DSHS on a regular basis. SBHO proposes sending the following information to DBHR to demonstrate network sufficiency:

- List of contracted providers
- Summary data on compliance with access standards, including intake within 10 business days and first routine appointment within 28 days from the request for service.
- Summary data on compliance with response time, including urgent and emergent situations.

Timely Access (**Question 277**)
SBHO will monitor timely access to care and the access standards outlined in the draft PIHP contract through a variety of quality management activities. Currently SBHO's quality management plan is structured into three tiers:

- Access
- Quality of services and
- Effectiveness (outcomes)

Each of these tiers has a variety of data collection, analysis, quality improvement tools and activities to measure for satisfactory compliance with both federal, state and contract requirements.

Historically SHBO (PRSN) has followed a process of closely monitoring and tracking measures over a significant period of time and if the data demonstrated satisfactory performance the measurement would change to a less intensive form of measurement. An example of the process would be a contract, federal or state required measurement that we then defined and measured in our Regional Performance Measures (examples of these indicators can be seen in **Exhibit 18 SBHO Policy 10.04 Quality Indicators**) with quarterly updated reports to our Quality Improvement Committee. This method allows us to both ensure compliance with both federal and state requirements, as well as with PIHP Draft BHO section 4 - Access to Care, section 5.2 - Appointment Standards and 5.3 - Authorization of Routine Services. For over a five year period SHBO (PRSN) quarterly measured the following for access:

- Routine outpatient authorization decisions within 3 days
- Inpatient authorization decisions within 12 hours
- Crisis response time (urgent within 24 hours and emergent within 2 hours)
- Intake assessment appointment within 14 days of request
- First routine appointment within 28 days from initial request
- First routine appointment within 7 days of discharge from inpatient episode

After demonstrating both, satisfactory scores for all our providers in the access measures, as well as sustainability for several years, SBHO moved these topics from an aggregate measure to a chart review measure. This is done with the understandings that if any concerns arise regarding an agency's ability to meet target goals, or if concerning trends are identified, the topic will be moved back to a more in depth measure and review process. By using this graduated measurement process we are able to utilize our limited resources in an efficient manner to continuously be studying, reviewing and improving various areas topics.

Hours of operation and ensuring overall adequacy of the network, in both the number of providers and hours the facility operates, are monitored through our annual administrative review. In addition SBHO monitors providers' penetration rates through a monthly process

Moving into the world of chemical dependency and mental health integration will require some changes to our process to ensure continued compliance with requirements of 42 CFR 438.206 (c) (1) (i-vi) and contract language. With both the changes from Medicaid expansion and also the integration of the chemical dependency system we want to ensure that we retain the progress we've made in our access measures. Specifically, we plan to reinstate the quarterly measures for:

- Routine outpatient authorization decisions within 3 days
- Inpatient authorization decisions within 12 hours
- Crisis response time (urgent within 24 hours and emergent within 2 hours)
- Intake assessment appointment within 14 days of request
- First routine appointment within 28 days from initial request

Also we are currently working within our Quality Improvement Committee to develop a meaningful measure for the coordination between inpatient and outpatient services. The previous seven day measure was a convoluted measure with much 'data noise' that distracted from any meaningful outcomes of the measure. Once a working definition is developed we will implement this measure as well.

For the substance abuse treatment provider, once we have verified the accuracy of the data submitted and collected, we hope to institute measures to ensure compliance with federal and state laws, as well as contract and SAPT block grant requirements. Some of the measures may include:

- Assessment within 10 business days.
- Ensuring that the GAIN-SS is completed by all clients aged 13 and older.
- Ensuring the priority population of pregnant women, IV drug users and postpartum women are offered assessments and treatment within the standards set in SAPT Block Grant (42 USC 300x-23 and 45 CFR 96.126).
- Work to establish a measure and gather a baseline on number of days between first contact and treatment.

As we actually begin the work of integrating the two behavioral health systems and have access to substance use treatment data we will most likely identify other areas that require improvement or at the least close scrutiny. We will of course be working closely with our new providers to collaborate on areas needing greater examination and supporting them as we develop quality measurement systems.

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Section V: Staffing and Workforce Development Plan

This section addresses SBHO's workforce and analysis plan for SBHO and ombuds staff. The training subsection, below, also discusses training issues as they relate to contracted providers under the new BHO system. Specific information on staffing and capacity at the provider level (network sufficiency) is addressed in Section IV: Network Analysis and Development Plan, under subsection ii Substance Use Disorder.

Section V. Subsection (i) Training

PRSN/SBHO has an annual training budget that pays for staff, ombuds, QRT members, and advisory board members to attend conferences and trainings. In addition, SBHO provides funding for contracted agencies to use in training clinicians on evidence based practices.

PRSN/SBHO also directly provides training and technical assistance to agencies on a variety of topics, including:

- Compliance with WACs, RCWs, and other regulations
- Compliance/Fraud and Abuse
- Documentation and treatment planning
- Coding
- Clinical issues
- Other topics as they arise or as a result of clinical or administrative audits

SBHO anticipates that newly contracted substance use disorder treatment providers will require a significantly greater level of technical assistance and training, especially on compliance with the administrative requirements of the new DSHS/BHO contracts. SBHO is increasing staffing levels in order to address this and other needs.

In addition, SBHO will continue to fund training of current and future staff on basic aspects of chemical dependency treatment. A recent example includes training on ASAM criteria. It is expected that, once hired, the SBHO chemical dependency manager will provide ongoing training to SBHO staff on substance use disorder treatment.

Section V. Subsection (ii) Personnel

SBHO's current organizational structure is attached as **Exhibit 44a**. Staff are responsible for general areas as indicated by job titles. However, many areas of responsibility are shared across positions. Current staff include:

- RSN Administrator
- Quality Assurance Manager
- Resource Manager and Compliance Officer

- Adult Services Manager
- Children's Services Manager
- Information Systems Manager
- (part time) Accounting Staff (2)
- Administrative Assistant
- (contracted with CommCare) Medical Director

After reviewing the new BHO contract requirements and assessing the current chemical dependency system's preparedness for these significant changes, SBHO determined additional BHO staff are needed to address:

- The level of technical assistance BHO staff will provide to SBHO chemical dependency agencies facing new and significantly greater contract requirements.
- The additional oversight and monitoring required of SBHO staff due to an increase from four providers (mental health only) to seventeen (mental health and chemical dependency).
- The need for chemical dependency specialist on the SBHO team.
- Increased data management due to the number and type of providers under the new system.

As a result of these needs, SBHO proposed the organizational structure attached as **Exhibit 44b** to the SBHO executive board, and has preliminary approval. Changes to the organizational chart include the following additions:

- Deputy Administrator (pending final approval)
- Chemical Dependency Manager (position posted)
- Inpatient and Long Term Care/Care Management position (pending final approval)
- QA Assistant (pending final approval)
- IS Manager and Data Analyst (One hired, one pending final approval)
- Compliance and HIPAA Officer (Anticipated to replace current Resource Manager position)

SBHO will continue to contract with CommCare to provide 24/7 authorization of care. CommCare currently provides all mental health inpatient and outpatient authorization services for PRSN, and has agreed to take on authorization for substance use disorder treatment.

Section V. Subsection (iii) Ombuds

PRSN/SBHO currently contracts with the Dispute Resolution Center (DRC) for ombuds services. SBHO plans to continue this contract with DRC, but will require DRC to hire an additional staff member to handle the anticipated increase in volume of cases. Both DRC ombuds staff will handle mental health and chemical dependency referrals.

Section VI: Financial and Administrative Plan

Under the Interlocal Agreement that created the Salish Behavioral Health Organization, it will be administered by Kitsap County, as the Peninsula Regional Support Network has been for the past 26 years. While administering the PRSN, Kitsap County has developed significant expertise in cost accounting, tracking the expenditure of funds through our contracted network. We regularly conduct financial reviews of our provider network, and we will continue to do so as the SBHO.

This paragraph addresses **Question 160** and **Question 161**. Under the Interlocal Agreement establishing the Salish BHO, the current Draft of which is attached as **Exhibit 31**, Kitsap County is identified as the Grant Recipient and Administrative Entity for the SBHO, and is responsible for entering into contracts as well as receipt and disbursement of funds, and employing staff. Each constituent County continues to provide local Millage funds to support the public mental health system, and all three counties have passed local 1/10th sales tax ordinances and administer those funds locally. The Executive Board has expressed the desire that the SBHO be better connected to local 1/10th efforts, and efforts will be made to have representatives of local Sales Tax committees also serve on the SBHO Board or otherwise integrate services closely with local Sales Tax efforts.

Kitsap County, as the Administrative Entity, has maintained a sufficient yet limited administrative structure which has maximized funding available for services within our Region. As the Salish BHO develops, it will be necessary to hire additional staff to oversee the provider network which will more than triple, but we are committed to doing so judiciously and maintaining as much direct service funding as possible. Expansion will take place in care management, quality assurance, information services, and finance, and staffing needs will be evaluated on an ongoing basis to ensure that sufficient staffing levels are achieved and maintained to monitor and provide oversight to the network of care.

Coordination of Public and Private Resources (**Question 19(2)**)

The PRSN has contracted with mental health providers on a sub-capitated basis, and will continue to do so after we become the Salish BHO. We will contract with substance use disorder agencies on a case-rate basis, with rates built to include a significant increase in Individual and case management services. Providers will be paid incrementally during the course of treatment, and will only earn the entire case rate if individuals complete care successfully. Providers will earn additional funds by increasing the numbers of individuals served, while over utilization will be controlled through administrative oversight. The Salish BHO will coordinate our services with all treatment courts in the local area, and providers will be required to have a comprehensive system of identifying and accessing third party payment options. As previously stated, coordination of efforts with those of local sales tax programs is an expectation of the county commissioners who oversee both programs, so will be an integral part of our program going forward.

Behavioral Health Organizations - Contracting Process (**Question 3**).
The Salish BHO intends to contract with Substance Use Disorder providers using a case rate system that is paid over the course of the treatment episode, with payments weighted so that agencies are rewarded when patients stay in services until it is clinically indicated that they have completed treatment. Follow-up support will also be built into rates so individuals are supported even after they complete their formal treatment episode. Providers will receive a case rate for each individual they enroll, encouraging expanded penetration.

The Salish BHO will work with contracting community mental health centers to develop new language to incentivize the prevention of re-admissions into inpatient treatment, and for increased penetration. It is anticipated that these incentives will be in agency contracts in July of 2016.

The community mental health agency network that the PRSN/SBHO contracts with has made incredible efforts to integrate their services with those of the medical community, and it is clear that they will continue to do so. One of our agencies (also contracting for SUD services) is operated by a public hospital district, two provide psychiatric support to their local hospital, one has a primary care provider on-site one day a week, and three of our contracting agencies have agreements to provide mental health staff to local primary care clinics, including to the new federally qualified health clinic in Port Angeles.

Integration of Services (**Question 5**)
The Peninsula Regional Support Network is dedicated to improved health for our members, and the integration and coordination of health care across systems and payors. We are actively working with the managed care plans on these efforts, and plan to have actionable projects underway prior to April of 2016 to solidify these efforts. Projects currently being vetted are MCO payment for mental health portion of co-occurring programs for individuals who do not meet access to care criteria, better identification and coordination of care for individuals in either one of our systems identified as high need in both areas (health and behavioral health), and expanded access to medication assisted treatment through the expansion of primary care physicians willing to and eligible to prescribe Suboxone. Each of these efforts has potential to save money and improve care for the enrolled population, and will be thoroughly explored.

The SBHO will continue to support contracting agencies in their efforts to integrate care, and will attempt whenever possible to make funding and payment design decisions which support integration efforts. Our mental health provider network has done an exceptional job of care integration, and a synopsis of their efforts follows.

Jefferson Mental Health Services:

- Outpatient psychiatric and PCP consulting with Jefferson Healthcare at two Port Townsend Jefferson Healthcare clinics with an MD Psychiatrist in Jefferson County

- Outpatient ARNP psychiatric consulting for Gray Wolf Ranch, adolescent and young adult CD facility in Jefferson County
- Outpatient ARNP psychiatric consulting for Port Gamble S'Kallam Tribe in North Kitsap County (by ongoing request)

Peninsula Behavioral Health:

Peninsula Behavioral Health has contracts with Olympic Medical Center, North Olympic Healthcare Network and Behavioral Health Northwest and provides the following services:

- Inpatient Psychiatric Consulting (MD - Olympic Medical Center - March 3, 2010 to present
- Outpatient Psychiatric Consulting (ARNP) - Olympic Medical Physicians Primary Care Clinics: 8th and Cherry, 8th and Vine (Port Angeles), and 5th Ave. (Sequim) – April 1, 2015 to present
- Behavioral Health Assessment and Counseling (LICSW)– Northwest Olympic Healthcare Network (Newly opened Clallam County Federally Qualified Health Center) – July 7, 2015
- Inpatient Transition and Home Health Care Management Services (Care Manages)– Behavioral Health Northwest – Clallam and Jefferson Counties November 20, 2012

Kitsap Mental Health Services:

Kitsap Mental Health Services has had a Centers for Medicare and Medicaid Services Integration grant for the last five years, and has devoted themselves to strong medical integration efforts.

- A Psychiatric Consultant is available real time to all primary care providers in Kitsap County via phone during weekday office hours to respond to diagnostic and medication management concerns, and to provide education for PCPs by request. During 2014, the Psychiatric Consultant provided consultation services to 38% or 66 of the County's 174 primary care providers.
- A full time Behavioral Health Professional (BHP) capable in both mental health and substance use disorder services provides brief intervention, screening, and referral services to four primary clinic sites operated by a major practice on a one day per week per site rotational basis. As a Community Behavioral Health Center employee, the BHP also facilitates bi-directional care and warm handoffs to the CBHC or to PCPs as needed, and convenes inter-professional collaborative care conferences in the community to support shared care plans for complex patients.
- KMHS has previously provided BHP services to the local FQHC and to support bi-directional care, is available to contract with area practices to provide BHP services if desired.

- Two major primary care practice groups provide primary care on-site at the main Kitsap Mental Health facility. This effort began with Harrison Health Partners providing a physician one day a week with a patient panel of 250, and will expand in January of 2016 when the local Federally Qualified Health Facility places a physician on-site an additional two days a week. Peninsula Community Health Services is currently the largest outpatient provider for the Medicaid community in the Kitsap County area, and their presence on-site at the KMHS facility will be a welcome expansion to integration efforts.

The SBHO will work with all Apple Health Managed Care Organizations to identify high need/high cost individuals from both sides and better coordinate their care. The intent is for mental health and substance use disorder treatment agencies to identify individuals with significant health issues, and Apple Health carriers to identify individuals with mental health and SUD issues that are currently untreated or not responding to treatment, and coordinate care much more aggressively for this population. This will become a focus of our work in the first quarter of 2016, and we hope to have standard protocols in place at the time we go live in April.

Payment for Treatment - Financial Ability of Patients (**Question 37**)
The Salish BHO will require that all contracting agencies have policies in place that include both sliding fee scales as well as a requirement that all non-Medicaid individuals seeking services are assisted with accessing Medicaid to determine if they qualify for that program. These policies will be evaluated during the pre-delegation site visit that will be conducted by the SBHO, and evidence of their enforcement and implementation will be reviewed during annual on-site administrative reviews.

Medicaid recipients will never be required to pay for a covered service, and agencies will be limited in what individuals not eligible for Medicaid may be required to pay in accordance with their approved sliding fee scale. The costs associated with any covered service will be explained to individuals upon enrollment.

Subcontractual Relationships and Delegation (**Question 290**)
The Salish BHO will conduct pre-delegation visits with all potential Substance Use Disorder agencies during the January – March, 2016 time period utilizing the draft tool included as **Exhibit 32** - Pre Delegation Review Tool DRAFT. The tool was initially distributed to potential contractors in August and September of 2015, and technical assistance offered for agencies to achieve compliance. The future SBHO will continue to work with agencies between September and January of 2016 to assist them in creating compliant systems of administration.

The SBHO will continue the system of agency monitoring that has been established by the Peninsula RSN, which involves four levels of oversight. The SBHO will conduct Agency Administrative Reviews for each agency annually. These are conducted by senior level clinicians, and in general mirror the pre-delegation review tool in **Exhibit 32**. Copies of three recent Administrative Reviews are attached as **Exhibit 37**. The Quality Review Team, made up of volunteers from the Advisory Board, conducts on-site reviews of each

agency every other year. These reviews include interviews with community members and ancillary agency directors, as well as interviews with agency staff. This level of review provides a different perspective on the system and services provided and has been valuable in building a more holistic picture of the quality of our system. Recent QRT Reviews are included as **Exhibit 25**.

In addition to these very intensive on-site reviews, the Quality Improvement Committee, made up primarily of agency quality assurance personnel but which includes Advisory Board members, reviews various statistical reports produced by Regional staff, discussing each agency's performance and establishing targets for regional performance measures collectively so there is better buy-in from provider agencies. Summaries of these statistical reports are reviewed by the Advisory Board and Executive Board. A copy of the mailing for a recent meeting of the Quality Improvement Committee, with its attachments, is attached as **Exhibit 43**.

Clinical reviews are conducted on an on-going basis by qualified clinical staff employed by the PRSN. This will continue under the SBHO, which will employ at least one full time qualified CDP. A cross section of clinical files are reviewed during the year, including crisis, inpatient, outpatient, and intakes for those who were judged to not meet Access to Care standards by contracting agencies. This level of clinical scrutiny will be put into place for Chemical Dependency contractors, with reviews distributed appropriately across the spectrum of care. Copies of recent clinical review feedback is attached as **Exhibit 15**.

Fiscal reviews are performed on each agency annually to ensure that funds are being appropriately utilized and reported. Recent Fiscal Reviews are attached as **Exhibit 39**, and all agencies are subjected to Encounter Data Validation annually, included as **Exhibit 40**.

All of these formal review tools and protocols are supplemented by on-going monitoring of service levels, authorizations requested by each agency, and each agency's ability to meet timeliness standards.

Criminal Justice Treatment Account (**Question 48**)

The Salish BHO will work with stakeholders throughout the region to ensure that Criminal Justice Treatment Account funds are used appropriately, and to develop community plans for their expenditure. The SBHO will meet individually with stakeholders in each community to review how funds have been used in the past, explain the funding changes which are happening, and the move to managed care for the majority of Substance Use Disorder treatment. It is expected that no changes will be made to the utilization of CJTA funds initially until the SBHO fully understands how the funds are allocated and utilized currently.

Meetings with key stakeholders will begin in September, and continue through go-live in April in order to ensure that there is complete continuity of care and that all parties are comfortable with plans going forward.

Ultimately, it is planned that CJTA funds will first be used to pay for treatment services for individuals who are not eligible for Medicaid and have no other means of paying for treatment, with a second priority being non-medically necessary services for the Medicaid population whose treatment costs can be paid for with Medicaid funds.

The SBHO will form local coordination panels in each of our constituent counties made up of the required individuals, and will work with those panels to develop specific funding plans for CJTA funds in each community. It is anticipated that panels will either be developed or the SBHO will begin managing them by June of 2016, with CJTA expenditure up to that time based upon each county's prior expenditure of funds. As local CJTA committees are identified and become active, the SBHO will use them to review expenditures and to develop plans for any change in expenditures or policies going forward.

Section VII: Utilization Management

The following section is meant to address the Utilization Management section of the detailed plan in general, as well as **Question 284**: "Describe your utilization management system and how it will be modified to provide all utilization management activities, including authorization of services, for substance use disorder services." AND **Question 24**.

Current Utilization Management System

Current Authorization of Services

PRSN/SBHO currently provides authorization for inpatient, outpatient, and residential mental health services through contract with CommCare, an ASO based out of St. Louis, MO. CommCare is available 24 hours a day, 7 days a week for inpatient authorization. CommCare's medical director has authority to deny requests for authorization of services.

Mental Health Level of Care Guidelines

CommCare is required to follow the PRSN/SBHO Level of Care (LOC) guidelines when making decisions about authorization of services. The LOC guidelines are included as **Exhibit 20**.

The LOC guidelines include detailed entrance and continuing care requirements for each level of care within the PRSN. PRSN/SBHO relies upon the state's access to care standards for entrance into mental health services. The LOC guidelines include specific criteria for non-Medicaid consumers seeking mental health services from PRSN/SBHO.

Current Utilization Management Plan

PRSN's utilization management plan is attached as **Exhibit 21**. The plan details the PRSN's current utilization management activities. Examples of these activities include (see **Exhibit 21** for full details):

- Monitoring the authorization process
- Establishing Levels of Care
- Tracking authorization and service delivery trends
- Evaluating network sufficiency
- Coordination of oversight activities with RSN clinical and QA staff
- Ensuring consumer rights
- Administrative reviews of providers, the ASO and ombuds
- Over and under utilization project
- Analysis of utilization management data

Incorporation of SUD Treatment into the Utilization Management System

SBHO will incorporate authorization of substance use disorder (SUD) treatment and related utilization management activities into the current PRSN UM process. SBHO will

update the Level of Care guidelines to include ASAM based levels of care. SBHO's plans to address these changes are addressed below.

Plans for Authorization as a BHO
SBHO will expand the contract with CommCare to include authorization of contracted substance use disorder services. This will include availability 24 hours a day, seven days a week for authorization of withdrawal management services beyond the initial 3 days.

Chemical Dependency Level of Care Guidelines
SBHO is in the process of developing and updating policies and procedures to meet contract and regulatory requirements for access and levels of care for chemical dependency treatment services in our region.

SBHO's levels of care guidelines will incorporate contract requirements as well as state and federal laws and regulations. All services will be based on ASAM placement criteria and the individual's DSM-5 substance use disorder diagnosis. Assessments must be completed by a CDP.

While development of the SBHO LOC guidelines is in process, and awaiting release of SUD treatment ACS by the state, the following sections describe SBHO's planned LOC concept.

Scope and Intensity of Treatment
Authorization of SUD treatment services will be based upon ASAM level placement. Level of care will be determined after an intake assessment by a CDP. For those individuals meeting ACS for outpatient services, SBHO will authorize one of two levels of care.

Level 1: Outpatient Services (ASAM Level 1). Expectations for this level of care include:

- Group or individual chemical dependency counseling sessions, each month, according to an individual service plan.
- Conduct and document an individual service plan review for each individual once a month for the first three months and quarterly thereafter or sooner.
- These expectations are expected to evolve over the coming months, as planning continues.

Level 2: Intensive Outpatient Services (ASAM Level 2.1). Expectations for this level of care include:

- Chemical dependency outpatient treatment services that provide a concentrated program of individual and group counseling, education, and activities, including at least one individual session each month.
- Conduct and document a review of each individual's service plan in individual counseling sessions, at least once a month, to assess adequacy and attainment of goals.
- These expectations are expected to evolve over the coming months, as planning continues.

Outpatient services available for these levels of care, based on ASAM placement and medical necessity, and after an intake assessment, will include (from DBHR's draft Chemical Dependency SERI):

- Case Management
- Opiate Substitution Treatment
- Outpatient Treatment (Group and Individual)
  - Brief Outpatient Treatment
  - Outpatient Treatment
  - Intensive Outpatient Treatment (Level 2 only)
- Interim Services: Only if awaiting residential placement

Individuals will be able to receive medically necessary outpatient services at or below their current ASAM level.

Residential services will require a separate authorization. SBHO will authorize the following levels of care for residential treatment:

- Level 3.1 Clinically Managed, Low Intensity Residential Services (Recovery House)
- Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential services
- Level 3.5 Clinically Managed, High Intensity Residential Services

Withdrawal management services will be available without an authorization for up to three days of treatment. Additional days will require further authorization. Withdrawal management will be authorized as:

- Level 1 WM Ambulatory withdrawal management with extended onsite monitoring, or
- Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)

Services that will **not** require an authorization include:

- Assessment (Intake)
- Crisis and Involuntary Commitment Services
- Brief Intervention (Triage Services)
- Engagement and Referral
- DUI Assessment
- Detox (Acute or Sub-Acute Withdrawal Management)—first three days do not require authorization

<u>Duration</u>
Initial authorization of services will be:

- 9 months for outpatient services
- 21 days for residential services

If an individual is in need of ongoing treatment, the agency will need to request further authorization. Ongoing authorization requests include:

- 6 additional months for outpatient services
- Additional days as medically necessary for residential and detox services

Continuation of Services and Discharge
In order to remain in services, individuals must continue to meet ASAM placement criteria for the level of treatment they are receiving. ASAM level must be reviewed on a regular basis according to WAC and other requirements.

CJTA Funded Services
SBHO is meeting with local judges and court staff to negotiate a process for authorization of specific levels of care for those individuals ordered into treatment by the court. The goal of these negotiations is to balance the court's requirements (court orders) on an individual basis, against the assessed level of care (ASAM placement).

Updates to Utilization Management Plan
The current PRSN/SBHO UM plan (**Exhibit 21**) will be updated to include the same level of utilization management oversight for SUD services as currently exists for mental health treatment in PRSN. A summary of planned changes to the current UM plan is outlined below.

- UM Management Plan Structure:
  - The plan will be updated to include language that makes it clear that the utilization management activities described apply to SUD treatment as well as mental health.
- Service Authorization for Routine Care
  - The new plan will include specific details for authorization of outpatient SUD treatment, as described above.
- Authorization of non-Routine Services
  - The UM plan will add authorization process descriptions for detox and residential treatment.
- Continuing Stay and Service Authorization
  - The new plan will describe continuing care requirements for SUD services.
- Ensuring Client Rights are Provided
  - The current oversight and monitoring activities will apply to SUD treatment providers as well.
- Oversight and Sampling Methodology
  - SBHO will conduct annual administrative reviews of SUD providers, just as it does with contracted mental health agencies.
- Over/Under Utilization Project
  - In the coming months, SBHO will develop an over and under utilization project that applies to over/under utilization in the SUD treatment system. Selection of measures for over/under utilization will be made in consultation with SUD providers and stakeholders.
- Examination of Network Sufficiency and Integration of UM Management Data
  - SBHO currently monitors authorization and service delivery data from several angles. This information is shared monthly with providers and is a regular topic of discussion at PRSN provider meetings. SBHO will create a

similar process for SUD providers. We anticipate that the first year of operation will involve developing baselines for many measures.

Services in Support of Core Services
Within available resources, SBHO will provide the following services to priority populations (RCW 71.24) using state funds:

- Payment of residential services not covered by Medicaid funds
- Provide or purchase clinically appropriate SUD outpatient services to non-Medicaid individuals who meet the priority population criteria described in the draft contract, and who were referred to services:
    - Through the criminal justice system, or
    - After being released from detox (sub-acute or acute withdrawal services)

Those individuals whose treatment is provided using state funds will receive the same service, based on ASAM placement and available resources, as Medicaid enrollees.

In addition, SBHO will, within available resources, pay for the following:

- Assistance with transportation to residential treatment
- Assistance with application for entitlement programs

Determining "Available Resources"
In order to determine whether there are available resources to provide the "Services in Support of Core Services" above, SBHO tracks revenue and expenditure monthly and longitudinally. Should SBHO determine that, over time, there is an excess of state funds, SBHO will reassess allocation of these funds toward specific programs.

Involuntary Commitment - Individualized Discharge Plan (**Question 124**)
SBHO currently provides discharge planning services to all consumers from our region at the State Hospital. We also provide discharge planning services for individuals for which we have authorized inpatient treatment at community hospitals and freestanding E&Ts. Currently, SBHO has one liaison at each of our four community mental health centers. Those liaisons are responsible for discharge planning for consumers in their agency's assigned catchment areas.

SBHO liaisons currently work with hospitals to develop individualized discharge plans. In order to meet the new requirements (effective July 1, 2018) that the SBHO work on transition to the community in the context of an individualized discharge plan within twenty-one days of the determination that the individual no longer requires treatment at the inpatient level of care, SBHO will take the following additional steps prior to July 1, 2018.

- Update the current SBHO policy on discharge planning to include the new requirements.
- Educate liaisons and their supervisors on the new requirement.
- Reassess current allocation of hospital diversion and step-down resources to determine if reallocation is necessary.

Current diversion and step-down (including step-down from the state hospital) resources include the crisis center in Clallam County and the Keller House residential center in Kitsap County, along with other housing and supported living options.

Behavioral Health Organizations - Transfers Between Organizations (**Question 187**)
SBHO follows current contract requirements addressing coordination and communication with other RSNs/BHOs when an enrolled consumer moves to another RSN/BHO.

State Hospital Inter-BHO Transfers
When any SBHO consumer at the state hospital plans to move to another region, the hospital liaison from the assigned SBHO contracted provider contacts the liaison from the receiving RSN/BHO. The liaison also works with the SBHO Clinical Manager to develop an inter-RSN agreement following the risk-factor approach outlined in the RSN/BHO's contract with DSHS. The Clinical Manager contacts the receiving RSN/BHO in order to finalize the inter-RSN transfer agreement. The hospital liaison works with the receiving BHO's liaison and/or future outpatient provider (depending on the preference for that region) in order to schedule an intake and arrange for housing.

The process for state hospital inter-BHO transfers is detailed in **Exhibit 50a**, SBHO Policy 11.25 Uniform Inpatient and Outpatient Inter-BHO Transfer Protocol on page 4 in the section titled "Uniform Transfer Agreement: State Hospital Inter-BHO Transfer Protocol".

PRSN/SBHO has also developed an agreement form, **Exhibit 50b**: SBHO Policy 11.25a Inter-BHO Transfer Agreement Form.

Outpatient Inter-BHO Transfers
In those cases where an individual is not in the state hospital and is relocating to another region, the RSN/BHO follows the same process as outlined above, if the individual is in need of specialized non-Medicaid services as defined in the contract.
The process for state hospital inter-BHO transfers is detailed in **Exhibit 50a**, SBHO Policy 11.25 Uniform Inpatient and Outpatient Inter-BHO Transfer Protocol on page 3 under the section titled "Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol: Outpatient Services Transfers".

Process for Transfers to a Fully Integrated Region
When an individual wishes or must move to a fully integrated region, SBHO will follow a process similar to the one described above. Instead of contacting the BHO, the SBHO will contact the individual's MCO in order to coordinate services. The SBHO assigned hospital liaison would arrange for an intake in the new area and help obtain housing and other services as necessary. SBHO has had ongoing communication with each of the plans that cover those areas planning for full integration. SBHO will request that each plan provide a specific contact for initiation of the inter-RSN transfer process. The MCO's contact will be who SBHO staff and agency liaisons communicate with during the transfer process.

Review of Admission and Inpatient Treatment of Minors **(Question 23)**
The SBHO will broker an independent review of all minor children by a licensed physician or Chemical Dependency Professional admitted to any inpatient facility under the auspices of parent initiated treatment. Integrating this requirement in conjunction with the initial authorization will support efficient completion and adherence to required timeframes. The SBHO will develop policies that directly support and clearly articulate provisions of RCW 70.96A.245 as well as afford consistent opportunities to monitor effectiveness through utilization management and quality management improvement committee strategies. The SBHO will provide training and technical support to all of its contracted providers and work collaboratively to address any and all collateral implications revealed through operationalizing these policies and procedures both clinically and administratively.

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Section VIII: Quality Assurance Plan

SBHO has a robust quality management plan that complies with both state and federal requirements, as well as contract requirements (**Exhibit 13 SBHO Policy 10.01 Quality Management Plan**). As stated in the plan, it is a living document that provides guidance for the evaluation, monitoring and improving of the behavioral health services delivered within the three counties served by the SBHO. The plan consists of activities, meetings and measures and includes collaboration from community, stakeholders, providers and consumers. The Quality Management Plan is reviewed frequently for accuracy and effectiveness, referred to for guidance and evaluated annually for continued improvement. The plan is approved by the SBHO Quality Improvement Committee (QUIC) and the Executive Board and facilitated by the SBHO staff.

The following section is meant to address **Question 4:** Behavioral Health System - Improvement Strategy.

SBHO has an in depth quality plan to address, not only the contract required performance measures, performance improvement projects and regional measures but also studies topics through a variety of quality tools that can impact the consumer's health status, employment, education, utilization of inpatient services, recovery, success in treatment and overall well being, in accordance with RCW 43.20A.895. We are also working closely with the state preparing as the July 2018 anticipated performance measures are implemented that will hopefully allow us access to data from ancillary systems.

Current topics for measure are discussed and decided upon through our Quality Improvement Committee which is comprised of consumers, consumer family members, stakeholders, providers, Ombuds and SBHO staff. Examples of SBHO's regional measures to increase client related outcomes and system efficiencies can be found in Policy 10.04 (**Exhibit 18 SBHO Policy 10.04 Quality Indicators**). In an effort to be as transparent as possible the BHO posts the annual Summary Quality Indicator Report on our website for public access.

SBHO will comply with Quality Assurance and Performance Improvement PIHP Draft BHO section 8. These goals will be met, in part, by:

1) Participating in the Department's Quality Management meetings and any additional subcommittees or activities;
2) Aligning our quality plan with the Department's Strategic Quality Management plan, per RCW 43.20A.895 (2);
3) Developing a detailed and specific implementation plan for our region to measure the integration of mental health and chemical dependency services, per RCW 43.20A.895 (2)(a)(iv). For further details on this plan, please refer to the response to question 292 in the "Quality Assessment and Performance Improvement Program' section below.
4) Participating in quality review activities required by the Department, including External Quality Review, PIHP Draft BHO Contract section 8.6.

5) Implementing and routinely revising practice guidelines that assist practitioners in the prevention, diagnosis, treatment and management of clinical conditions that are most appropriate for our region's population, PIHP Draft BHO Contract section 8.5.
6) Working closely with the Department to increase and track the use of research and evidence based practices, per RCW 43.20A.895 (2)(a)(ii) and (d).
7) Conducting encounter data validation (EDV) studies, at a minimum once a year. The EDV will comply with all contract requirements and results will be reported to the Department, per PIHP Draft BHO Contract section 8.7.
8) Measuring and monitor core performance measures as required by contract to include: psychiatric readmission, mental health penetration, substance use disorder treatment penetration and substance use disorder retention, per PIHP Draft BHO Contract section 8.8.2.
9) Having a minimum of three performance improvement projects that are designed to achieve through ongoing measurements and intervention, significant improvement over time in clinical care, non clinical and substance use disorder treatment practices, PIHP Draft BHO Contract section 8.8.1.
10) Having regional performance measures that are developed, calculated, tracked and reported to the Department, PIHP Draft BHO Contract section 8.8.4.
11) Monitoring workforce capacity, efficiency, stability, diversity and safety through administrative reviews and annual reports per RCW 43.20A.895(2)(a)(v).

Evidence Based Practices (EBP):

Pursuant to, RCW 43.20A.895 (2)(a)(ii) and (d) and in compliance with PIHP Draft BHO section 8.9, SBHO will design and administer systems to achieve improved outcomes for adult clients served by those systems through increased use and development of evidence-based, research-based, and promising practices as defined in RCW 71.24.025. SBHO will demonstrate compliance with this regulation through policy 11.15 Use of Evidence Based Practices (**Exhibit 19 SBHO Policy 11.15 Use of Evidence Based Practices**). SBHO has a current process to track all child/youth EBPs through SERI codes on encountered services, as well as a certification, semi annual process by providers attesting to the training and standardization of research evidence based practices they provide to clients. As the Department approves the EBP inventory for adults and older adults SBHO will incorporate these practices into our process and tracking system.

SBHO is currently working with chemical dependency providers to develop a comprehensive list of research and evidence based practices that are utilized in our region. To date we've found that our chemical dependency providers utilize a variety of EBPs including:

- Motivational Interviewing
- Moral Reconation Therapy
- Trauma Informed Care, Housing First
- Harm Reduction

- WRAP (certified model)
- Journals from the Change Company
- 12 Step Facilitation
- Cognitive Behavioral Therapy
- Seeking Safety
- Gorski-Relapse Prevention
- Education Growth- Cognitive Behavioral Therapy
- Behavioral Contracts
- Family Therapy
- Smoking Cessation
- Strength Based Treatment Planning/Aftercare Planning

We will continue to work on developing a comprehensive inventory of EBPs offered from our substance use disorder providers. In addition we will be working to expand our current monitoring and tracking process to our new substance use disorder providers.

Core Performance Measures:

SBHO has been an active participant in the Department's HB 1519/ SB 5732 work group and has been involved in defining and establishing performance measures for both the mental health and chemical dependency provider contracts. These meetings, as well as the State's soon to be released Strategic Quality Plan, will shape and drive future modifications to our Quality Plan. SBHO will meet the Core Performance Measures as described in the PIHP Draft BHO section 8.8.2 contract as follows:

#1 Core Performance Measure: Psychiatric Hospitalization Readmission Rate: the proportion of acute psychiatric inpatient stays during the measurement year followed by an acute psychiatric re-admission within 30 days. This measure will be a modified version of the NCQA HEDIS "Plan All-Cause Readmission" metric.

SBHO has measured this topic consistently over the years and will continue to measure readmissions in our region for the population that we can access data. Moving forward we understand the state, in an attempt to align with PCMM measures, will be including dual eligible populations that the BHOs don't have complete data on in order to evaluate our performance. Our historic data shows a decline in readmissions in our region from years 2012 and 2013 and a slight increase in calendar year 2014 (**Exhibit 18 SBHO Policy 10.04 Quality Indicators)**. This trend corresponds to the baseline data the state has provided, although the actual percentages vary between the two reports. In attempt to provide quality care, appropriately utilize our resources and comply with contractual requirements SBHO plans to address the topic of readmission in three ways.

1) SBHO will continue to work with the Department to ensure an understanding of the measure and confirm compliance.

2) SBHO will continue to measure readmissions from regional data available to watch for anomalies and variations from the baseline as well as overall trends.
3) SBHO is implementing a readmission project with providers to study factors that appear to directly affect readmission potential. This study is done with the intent to create an intervention for this identified population with the goal of improving successful inpatient to outpatient transitions and reducing overall readmission rates.

#2 Core Performance Measure: Mental Health Treatment Penetration: Percent of adults identified in need of mental health treatment where treatment is received during the measurement year. This measure will be defined by DSHS and required of all RSNs.

SBHO has a monthly measure for provider performance that includes a measure of penetration for each provider and the region as a whole. We also measure penetration by Standard Medicaid versus the MAGI population to ensure both populations have adequate access to services.

Due to the parameters defined in the Department's measure it becomes another example of a measure that we will be unable to replicate at the BHO level due to not having access to ancillary provider data. However, we will continue to measure penetration for our region with the data we have available for both consistency of the measure and to observe for any potential data trends. In an attempt to match our measure as closely as possible with the state we will be separating our data measure from all clients who receive an eligible service into two measures, one for adults and one for children and youth.

#3 Core Performance Measure Substance Use Disorder Treatment Penetration (to be defined before the contract start date).

Currently substance use disorder providers utilize the TARGET system to monitor this performance measure. Unfortunately the TARGET system is scheduled to be discontinued by the state. Further, this measure has not been fully defined by the Department and therefore we are unable to create our correlating measure. SBHO has been a consistent and active participant in the state's HB 1519 / SB 5732 meetings as work is being done to define these measures and will continue to participate in these activities going forward. As the state defines this measure SBHO will develop an appropriate and correlating measure to permit us to view data in a closer to real time status and will allow us to drill deeper into the client level data to investigate and address any potential anomalies.

Finally, SBHO has contracted with a software development company to build a complete data infrastructure for our region. This system will be equipped with the ability to record all services provided within our region as well as report on a client level or aggregate level for both contract required measures as well as, client outcomes and system efficiencies.

Moving forward SBHO will:

1) Continue to attend and work with the state to define these measures;

2) Capture the TARGET data currently entered into the system to use as a baseline against future measures;
3) Work to develop a correlating measure within our new data reporting system.

#4 Substance Use Disorder Retention Core Performance Measure (to be defined before the contract start date)

Currently substance use disorder providers utilize the TARGET system to monitor this performance measure. Unfortunately the TARGET system is scheduled to be discontinued by the state. Further this measure has not been fully defined by the Department and therefore we are unable to create a correlating measure. SBHO has been a consistent and active participant in the state's HB 1519 / SB 5732 meetings as work is being done to define these measures and will continue to participate in these activities going forward. As the state defines this measure SBHO will develop an appropriate and correlating measure to permit us to view data in a closer to real time status and will allow us to drill deeper into the client level data to investigate and address any potential anomalies.

Moving forward SBHO will:
1) Continue to attend and work with the state to define these measures;
2) Capture the TARGET data currently entered into the system to use as a baseline against future measures;
3) Work to develop a correlating measure within our new data reporting system..

Performance Improvement Projects

SBHO, in compliance with the PIHP Draft BHO section 8.8.1, will develop performance improvement projects that determine where improvement is needed, in alignment with the DSHS Strategic Plan. We will continue to conduct or implement at least three (3) Performance Improvement Projects (PIPs), at all times during the Agreement period. PIPs are designed to achieve, through ongoing measurements and intervention, significant improvement, 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. SBHO will at all times be conducting two (2) clinical PIPs and one (1) non-clinical PIP. One of these three (3) PIPs shall be a Children's PIP. Additionally, one (1) of the PIPs shall be specific to substance use disorder treatment practices.

Currently SBHO is conducting two PIPS, a Tobacco Cessation PIP (clinical) and a Children's Intensive Services (Children's; non-clinical) PIP. Both PIPs have received satisfactory feedback from the external quality review organization and the Department.

Moving forward, SBHO will incorporate a third PIP, ensuring that one of the PIPs focus on substance use disorder treatment. Before a PIP topic can be determined, a great deal of research and time is typically spent identifying a significant need for system improvement, determining if necessary data is available, studying baseline data, and incorporating community, stakeholder and provider input. As we are stepping into the new clinical world

of chemical dependency we have much learning to do and have begun preparing for this new project by having discussions at the Quality Improvement Committee regarding a substance use disorder treatment PIP.

Regional Performance Measures

SBHO, in compliance with PIHP Draft BHO section 8.8.4 will develop Regional Performance Measures for the chemical dependency providers that are calculated, tracked and reported to the Department. SBHO will collect and manage the data necessary to support the Regional Performance Measurement activities, including establishing the baseline, determining demonstrable improvement targets, tracking change in performance over time, and reporting the annual findings to the Department. The Regional Performance Measures Report will be submitted to DSHS annually. SBHO will chose Regional Performance Measures based on local relevance, clinical consensus, and research evidence and with input from the Quality Improvement Committee and Advisory Board. SBHO will develop the Regional Performance Measures that reflect the following areas:

- Access and Availability
- Care Coordination and Continuity
- Effectiveness of Care
- Quality of Care
- Hope, Recovery, and Resiliency
- Empowerment and Shared Decision Making
- Self-Direction
- Cultural Competency
- Health and Safety Measures
- Consumer Health Status and Functioning
- Community Integration and Peer Support
- Quality of Life and Outcomes
- Promising and Evidence-Based Practices
- Provider effectiveness and satisfaction
- Integrated Programs and Systems Integration

Currently the BHO conducts and reports to DBHR, Regional Performance Measures on peer service hours provided, inpatient utilization and access. In addition we are measuring coordination of children's services, evidence based practices, coordination from inpatient to outpatient, data completeness and data timeliness (**Exhibit 18 SBHO Policy 10.04 Quality Indicators).** Moving forward, SBHO is working to develop a measure for retention of transitional age youth, coordination between inpatient and outpatient and ancillary provider satisfaction in the mental health system, in addition we are adding chemical dependency measures for access and timeliness of substance use disorder services.

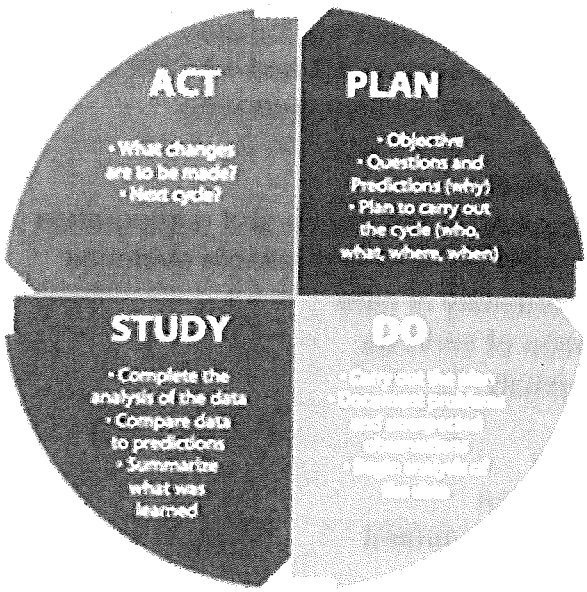
Quality Assessment and Performance Improvement Program (**Question 292**)
Currently SBHO's Quality Management Plan focuses on the compliance with PIHP Draft BHO section 8, State Draft BHO section 5.3 and 42 CFR 438.240 by emphasizing continuous improvement within our system regarding:

- Cultural competency
- Age appropriate services
- Commitment to recovery, rehabilitation and reintegration philosophies
- Clinical practices based on valid and reliable evidence
- Coordination and continuity of care
- Appropriate utilization of services
- Maintenance of capacity
- Accessibility
- Enrollee participation
- Stakeholder participation
- Continuous system improvement

In an effort to comply with both PIHP Draft BHO section 8 and 42 CFR 438.240, SBHO has created a diverse and comprehensive Quality Assurance plan. As we move forward in the integration of chemical dependency and mental health we will be working with our new providers to:

- Ensure adequate representation from both the chemical dependency system and consumers at our regional Quality Improvement Committee;
- Thoroughly assess the current quality system for our chemical dependency providers;
- Determine strengths and weaknesses of their current plan;
- Inventory all current and historic data and complete an encounter data validation to verify accuracy, completeness and timeliness.
- Collaborate with our providers and the Quality Improvement Committee to identify regional measures and performance improvement projects that help to strengthen the efficiency, effectiveness and outcomes of our system.

As we collect and review all data to create a comprehensive quality plan that is inclusive of mental health and chemical dependency, as well as in alignment with the state's strategic quality management plan we will be using the Plan, Do, Study, Act model to allow for rapid improvement.



The PDSA cycle is a four stage model that allows for rapid improvement through an organized continuous problem solving process. The model utilizes the testing of a solution or theory in a smaller scale initially, which allows for greater control, reduction of waste and preventing unnecessary system changes until a solution has been identified.

As we enter the unchartered territory of merging the mental health and chemical dependency systems a controlled approached is necessary. The PDSA model offers frequent opportunities to study and analyze the data and permits small scale testing of ideas before impacting the system as a whole. This approach also complies with the intent of SMM 2091.7 which requires a consistent and systematic method of data collection, frequent analysis and the ability to make needed changes.

In addition to the quality activities described in detail in the section above **(addressing question 4)** SBHO also reviews additional topics that rise to our attention and are monitored through a variety of quality assurance tools. The tools utilized in our quality management plan are selected to ensure the broadest view possible of the system from client level data to aggregate data. The activities include:

Chart Reviews: Currently SBHO audits provider's client charts to review for access, fidelity to practice guidelines, appropriate levels of care, medical necessity, compliance with GAIN-SS, consumer voice and input in treatment, treatment goals are measureable, support for employment goals, over and underutilization, coordination of care with PCP and other community resources, treatment is appropriate to the client's age, culture or needs, that a crisis plan has been completed if needed, as well as other clinically required documentation.

As we move into integration, SBHO is hiring at least one chemical dependency professional that will perform equivalent clinical chart reviews for our substance use

disorder providers and ensure compliance with PIHP Draft BHO section 9.11, WAC 388-865-0280 and other federal and state regulations.

Quality Indicators: In the 2013-2014 year SBHO had eight indicators including: inpatient utilization, child and family team meetings, peer service hours, access to services, coordination of care from inpatient to outpatient, data integrity, timeliness of periodics and timeliness of encounters, in addition to the contract required core performance measures.

Moving forward, and in compliance with PIHP Draft BHO section 8.8.2 and 42 CFR 438.240(c) we will be working with the substance use disorder providers to establish similar quality indicators for our region, in addition to the contract required core performance measures. Topics that are being considered to date include measures for access to services, referrals and coordination between mental health and substance use disorder providers, data completeness, accuracy, and timeliness, as well as access and timeliness of services.

Annual Reports: In addition to the quality indicators, there was an annual review of previous measures to ensure gains made were sustained. These included: EPSDT, Evidence Based Practices, GAPS, HIPAA, and region wide consumer satisfaction survey questions.

Moving forward SBHO will be developing equal and relevant regional measures, as well as overall annual review measures within our chemical dependency system in compliance with 42 CFR 438.240(c).

Grievances: PRSN has measures in place to monitor grievances on an ongoing basis with the assistance of the Ombuds. This includes a comprehensive system that is described in detail in Section X: Grievance System Plan, as well as quarterly tracking of complaints per contractor and semi-annual reports submitted to the Department and annually to QUIC.

As we merge with chemical dependency services we will integrate our comprehensive grievance system into both our mental health and the chemical dependency system. These changes will ensure compliance with both federal and state requirements and PIHP Draft BHO section 6.

Incident Reporting/Sentinel Events: Incident reports are monitored as they come in, tracked and compiled for further analysis and summary review. The Sentinel Events Summary report is provided to the QUIC annually.

Moving forward, SBHO will be monitoring incidents and categories of events as well as the system of care involved in each case for further analysis, trend tracking and review.

Administrative Review: Annual administrative reviews monitor the PIHP and state contracted delegated administrative activities as well as the agency administrative

activities. There is a focus to ensure recent changes to state laws, contract and federal regulation are implemented.

Moving forward, we will continue conducting annual administrative reviews of all our providers, both mental health and chemical dependency to ensure state laws, federal regulations and PIHP contract requirements are adhered to.

Sub delegation Reviews: Annual reviews monitor the PIHP and state contracted sub delegated administrative activities. There is a focus to ensure recent changes to state laws, contract and federal regulation are implemented.

This process will be incorporated into both systems to ensure compliance with all federal, state and contractual requirements.

Provider Performance Summary: Measurements are taken monthly for each provider, as well as by region to monitor trends in overall service hours, hours of service by modality and penetration rates by standard and MAGI funding.

Moving forward we will continue this process and include the substance abuse treatment providers. This will allow us to gather data on penetration rates by modalities and service hours provided.

Utilization Management Reports: Under and over utilization are measured and monitored through a variety of processes. Over utilization is primarily monitored through our authorization process. From both inpatient and outpatient authorizations there are processes and reports which allow us to measure utilization by provider. For under utilization we review denials through a clinical review of intakes, by using a GAPS report which allows us to monitor for clients who have not received adequate services within a three month time period and also by our monthly provider performance reports which document services provided by hours, modality and overall penetration. These measures are compliant with 42 CFR 438.240 (b) and PIHP Draft BHO section 5.8.

As we move forward we will be assessing data available and incorporating utilization review methods and processes for our new chemical dependency providers that also comply with these requirements. Some of these may be a clinical review for ASAM levels of care to determine appropriate levels, attendance, utilization and reviewing those who don't meet access to care.

Performance Improvement Projects (PIPS): To date, SBHO has two in process at all times. These are:

1) A children's PIP, which was created in compliance with DBHR's contract requirement. The PIP created a standardized method to identify the most intensive needs children and youth in our region. The initial standardized method was evaluated throughout the year to ensure that the method was accurately identifying the target population. By the end of 2014 we had completed our first full year of measurement.

2) A tobacco cessation PIP which has two phases began this year. The first phase is focused on asking each consumer, age 13 and older who present for prescriber appointments, about their current and historical tobacco use, and recording this data in the EMR. The second phase will include a focus on further intervention with those who report tobacco use, as well as collection of outcome data.

Moving into 2016, SBHO will be working with all of our providers to select a topic for a third PIP that is meaningful to our region. Selecting a PIP topic is an onerous project to ensure that data is readily available, the topic is measurable, improvement is feasible and the results will have a favorable effect on health outcomes and enrollee satisfaction. We have begun the discussions with our new providers regarding PIPs and are in the planning stages to remain in compliance with PIHP Draft BHO section 8.8.1 and 42 CFR 438.240 (d).

Quality Review Team (QRT): SBHO has an established QRT that monitors and evaluates the efficiency, effectiveness and benefits of services for people with mental illness within the region. The QRT meets regularly and conducts site visits to assess and evaluate services provided for SBHO consumers.

As we move forward with integration we will establish a second quality review team to represent consumer interests in the chemical dependency domain and also ensure we are meeting requirements of WAC 388-865-0282 while also ensuring we comply with 42 CFR.

Surveys: Currently SBHO utilizes both the MHSHIP surveys, as well as provider surveys of individuals served within our region. We have also implemented a process to include a regional standardized set of questions in the provider surveys for consistent comparison across the region and review this data at QUIC annually.

Moving forward we will be instituting this process with our chemical dependency providers as yet another means of gathering data on consumer satisfaction with services and the quality and efficiency of the system as a whole.

Quality Management Plan and Evaluation: Annually, SBHO's Quality Assurance manager, with input from stakeholders, conducts an evaluation process to evaluate the quality assessment and performance improvement program. Each measure and activity is evaluated for the impact and effectiveness on the services furnished to the enrollees, and health outcomes and enrollee satisfaction.

As SBHO incorporates chemical dependency services into our system we will incorporate this process into the overall quality assessment and performance improvement plan applicable to chemical dependency services in compliance with PIHP Draft BHO section 8.

In summary, by utilizing the already established quality measures we will be able to assess the quality, utilization, efficiency and satisfaction of services without creating entire new measures. With this baseline of data we will work to identify strengths and opportunities for growth within the newly combined system. As we identify future quality

improvement projects there will be specific measures developed that will address the specific needs of our region.

We will also utilize our current structure of providing technical assistance to providers who struggle in any particular area. During this process we also require a corrective action plan, per policy, (**Exhibit 49 SBHO Policy 9.11**) for providers who fall below the contracted requirements to help give structure support and definitive work plans with attach time lines to the process.

In addition to the above listed quality assurance activities, SBHO plans to:

- Complete an initial encounter data validation within the first quarter of chemical dependency service encounters that are submitted to verify accuracy and completeness of data submitted.
- Initiate a semi annual meeting with allied service providers to increase communication and effective coordination between ancillary systems.
- Establish a system and process to monitor and measure referrals between systems and coordination of care.

SBHO feels that approaching the new system with the organization symptomatic of the PDSA model and equally focusing on both ensuring open communication with our providers and allied systems, as well as gathering accurate data on the current system will allow us to gain a comprehensive understanding of the strengths and needs of the system. With this knowledge we will move forward with our continuous improvement strategies utilizing the current SBHO model of providing guidance, technical assistance and structured support. These plans will be implemented by and under the guidance of the Quality Assurance Manager, Michelle Alger MA, LMHC, NCC.

Section IX. Program Integrity Plan

This section provides a comprehensive assessment of our current compliance with all State and Federal Program Integrity System requirements, regulatory and contractual. For any deficiencies identified this plan provides a detailed work plan to correct the deficiencies to be completed no later than April 1, 2016.

The Peninsula Regional Support Network (PRSN), which will become the Salish Behavioral Health Organization (SBHO), has been in existence since 1989, with services beginning in January of 1990. Since 2005, the PRSN has been subject to External Quality Reviews by entities contracted with Washington State to conduct reviews of PIHPs in the State to assess their compliance with the Code of Federal Regulations.

The Salish BHO will adopt the PRSN's existing compliance procedures, and will modify them to include language pertinent to individuals accessing Substance Use Disorder (SUD) treatment services who are our members. These will constitute minor changes, which will allow us to maintain full compliance with CFRs related to program integrity. The PRSN will conduct a training program for SUD treatment providers which we anticipate contracting with between September 2015 and April of 2016 to ensure that they are fully informed as to the CFR requirements for Program Integrity, and will conduct a review of treatment providers program integrity policies prior to entering into contracts with them to ensure their compliance with CFR. SBHO will provide ongoing support to providers as the PRSN transitions to the SBHO as it will be critically important to ensure SUD treatment providers have access, at least in the transition, to support from SBHO staff to best understand program integrity requirements and expectations.

The SBHO will include this program integrity Plan within SBHO polices and procedures. The SBHO policies and procedures will be published on the SBHO website, a public forum to inform clientele of the pertinent program integrity rights under Federal Medicaid law, CFR, RCW, WAC and contract requirements.

The PRSN's existing policies and procedures are fully compliant with all contractual, state and federal laws such as the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act. In addition all federal and state regulations are met in every way herein set forth. PRSN policies and procedures devote an entire chapter to this important requirement and are subject to an annual review. If at any time any policy or procedural document is determined to be in need of update, amendment, or deletion the policy or procedure is modified accordingly as soon as possible, even outside the annual review.

BACKGROUND AND PURPOSE

The Salish Behavioral Health Organization (SBHO) strongly embraces the values of accountability and responsibility in order to ensure compliance with all local, state, and federal laws governing daily operations. The SBHO understands that accountability must be balanced between the expectations of the individuals served, provider agencies, community, and inter-governmental efforts between counties, the state and federal

agencies and institutions. The term "compliance" is an ethical and moral commitment to carrying out our mission in the most effective manner possible to reduce the occurrences of Medicaid fraud and abuse in the healthcare industry. The SBHO Program Integrity Plan establishes a culture within the network that promotes prevention, detection, and resolution of instances of conduct that violate this plan and federal and state law; and federal and state funded health care program requirements, such as the False Claims Act.

SBHO Executive Board, Advisory Board, and Quality Review Team (QRT) members, SBHO Administrator and staff, and network contractors and subcontractors that encompass the operations of the SBHO are expected to comply with the SBHO Program Integrity Plan. These parties have a history of working together to achieve and improve upon outcomes through such efforts as strategic planning, staff training and development, numerous feedback loops to effectively monitor and ensure progressive outcome measurements lead to improved policy and procedure development, and the implementation of agency wide best practices. Under the SBHO, network contractors and subcontractors are required to develop internal compliance plans, with a designated agency Compliance Officer, that compliment the SBHO Program Integrity Plan.

The SBHO policies and procedures will include compliance program requirements, which are an integral part to the Program Integrity Plan. Appropriate and knowledgeable staff will be available to explain the policies and procedures. At least annually SBHO will assess and update policies and procedures, as necessary. Updated policies and procedures will be published on the SBHO website. The SBHO is committed to implementing a strong compliance program that includes education, routine monitoring, accessible and responsive network compliance officers to minimize the occurrence of Medicaid fraud and abuse in the network.

Input from Individuals Served and Family Members

The SBHO has learned the value of being responsive to our community and individuals within our community. We have learned to keep an open ear and continuously incorporate input from the individuals and families we serve to ensure culturally appropriate and meaningful improvements to our service delivery. In order to ensure continuous feedback from individuals that access our services we have implemented several benchmarks including, but not limited to, SBHO Advisory Board (comprised of 51% client or family member representation, Quality Review Team (comprised of 100% client or family member representation), Quality Improvement Committee (comprised of client, family, and network provider membership).

Diversity

The PRSN understands the importance of ensuring the individuals that access our services are treated with dignity and respect in a manner that is consistent with their individual culture, age gender, sexual orientation, spiritual beliefs, socioeconomic status and language. The SBHO will continue this perspective and commitment. The SBHO will strive to provide annual cultural competency training to staff and the network.

Confidentiality
Individuals served by the SBHO network providers have the right to expect total confidentiality regarding their receipt of services, as well as the details of the services. Information designated as confidential will not be discussed with anyone other than on a need to know basis. All SBHO represented parties, such as Advisory Board and QRT members, who access confidential information, must sign the SBHO Oath of Confidentiality Statement. SBHO network contractors and subcontractors authorized to access confidential information must sign a Business Associate Agreement and treat the information as protected and confidential health information.

The SBHO will protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR 431.300 through 431.307, RCWs 70.02, 71.05, 71.34, and for individuals receiving SUD services, in accordance with 42 CFR Part 2 and RCW 70.96A. The SBHO will have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded behavioral health services. Pursuant to 42 CFR 431.301 and 431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement and the State Medicaid Plan. Such purposes include, but are not limited to:

The SBHO will (and require its subcontractors and providers to do so) establish and implement procedures consistent with all confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA)(45 CFR Parts 160 and 164) for medical records and any other health and enrollment information that identifies a particular Enrollee.

Current PRSN Confidentiality policies and procedures will be amended to reflect HIPAA requirements for all behavioral health services and will be posted on the SBHO website. Training will be provided for staff, network providers, and other SBHO represented parties who seek authorization to access confidential information.

Current annual reviews for each network provider includes a HIPAA tool. This tool will be amended to be included in all behavioral health annual reviews. This tool will assist in measuring the quality of confidentiality and the effectiveness of the trainings regarding HIPAA.

Standards of Conduct
The PRSN has a long history of being committed to conducting all business in compliance with applicable state and federal standards, including state laws and regulations, the SBHO contracts with the State of Washington, as well as federal regulations and laws. This commitment will be carried on as the PRSN transitions to the SBHO. It is the expectation of the SBHO that staff, board members, volunteers and contracted agencies and staff will all comply at all times with all pertinent governing regulations.

Prior to April 1, 2016 a written Code of Conduct will be implemented and distributed to all SBHO staff and subcontractors. SBHO will ensure that the performance of job

responsibilities is consistent with the Code of Conduct. The Code of Conduct will include, but not be limited to:

- SBHO commitment to comply with all applicable Federal and State program integrity standards, including proper payments to providers and methods for detection of fraud, waste, and abuse;
- SBHO's requirement that all of its Covered Persons are expected to comply with all Federal health program requirements and with SBHO's own policies and procedures;
- That all SBHO Covered Persons will be expected to report to the Compliance Officer, or other appropriate individual designated by SBHO, suspected violations of any Federal health care program requirements or SBHO policies or procedures, and
- The right of all individuals to use the Disclosure Program and SBHO's commitment to non-retaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

The Code of Conduct will be included in the SBHO policies and procedures. The SBHO policies and procedures will be published on the SBHO website, a public site, which is available to all Covered Persons.

SBHO Corporate Compliance Officer and Committee

The PRSN ensures that the accountability and continuous compliance with immediate oversight of the monitoring and reporting of matters are delegated to the PRSN Corporate Compliance Officer (CCO), a PRSN senior management position. This same accountability and compliance standard will be delegated by the SBHO to the SBHO CCO. As it was with the PRSN, the SBHO Compliance Officer will have direct access to SBHO legal advisors and the authority to report and investigate concerns. The SBHO will designate a Compliance Committee, and the Compliance Officer will be responsible for training the committee regarding compliance issues, the Compliance Plan, and informing the committee of all suspected instances of Medicaid fraud and abuse that are reported.

The SBHO Compliance Officer training includes, at a minimum:

- Review of the SBHO Compliance Plan, Compliance Activity Checklist and related polices and procedures
- Review of the SBHO network provider monitoring tools
- Review of the SBHO correspondence and required reports to the Washington State Medicaid Fraud Control Unit (MCFU)
- Review of the Center for Medicare and Medicaid Services (CMS) Medicaid Fraud and Abuse publications and reports
- Review of additional information presented at Medicaid fraud and abuse trainings sponsored by governmental authorities such as a county, Tribe, state, or CMS
- Review of compliance training material from MCFU, EQRO and other trainings.

As of April 1, 2015 the SBHO Compliance Officer is the contact point for ensuring:

- Policy, procedure, and practice development, as it relates to SBHO compliance

- Timely assessment of compliance issues, including monitoring the day to day compliance activities engaged in by SBHO.
- Timely investigation of violations
- Violations, suspected or known, are reported to the appropriate governing bodies and agencies.
- Adequate trainings are provided to SBHO staff, SBHO Board members, SBHO Committee members and network providers. Available training opportunities are announced.
- The provision of activities according the SBHO Compliance Plan
- Corrective measures are implemented, when needed
- Revised compliance requirements are communicated to network, such as contract amendments
- Facilitate the SBHO Compliance Committee meetings, maintain Compliance Charter and related documents
- The SBHO Corporate Compliance Officer duties also include the writing, monitoring and reporting of violations of policies and procedures that include a no-reprisal approach to the reporting of violations and time frames for investigating violations related to Medicaid fraud and abuse.

The Compliance Committee will include the Compliance Officer and other members of senior management necessary to meet the needs to ensure appropriate compliance program. The Compliance Officer will chair the Compliance Committee and the Committee will support the Compliance Officer in fulfilling his/her responsibilities. The Compliance Committee will meet at least quarterly.

Duty to Notify Regarding Federal Exclusion and Legal Status
The SBHO will not willingly contract with nor retain any contractor or subcontractor who has been listed by a state or federal agency as debarred, excluded or otherwise ineligible for federal or state program participation or whose license had been revoked or suspended. If either of these situations apply or if they become applicable, they must be reported to the SBHO Corporate Compliance Officer as soon as possible.

Excluded provider verification is conducted at time of hire or appointment, and every month thereafter. This verification is conducted through the HHS OIG website (http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp).

Ownership disclosure. The SBHO, network agencies and subcontractors must disclose whether a person (individual or corporation) with an ownership or controlling interest in the organization is or has a relative with ownership or 5%+ more interest.

- A network agency is required to maintain a list of employees and subcontractors with an ownership or control interest.
- Exclusion reviews must be conducted on individuals with ownership interest.

Reporting Medicaid Fraud and Abuse
Medicaid Managed Care Fraud means an intentional deception or misrepresentation made by a person that the deception could result in some unauthorized benefit to himself or

some other person and includes an act that constitutes fraud under applicable federal or State law.

Medicaid Managed Care Abuse means provider actions that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care.

It has been the policy of the PRSN and will be the policy of the SBHO to consistently and fully comply with all laws and regulations pertaining to the delivery and billing for services that apply to the SBHO's participation in the federal Medicaid and state funded behavioral health programs. The SBHO Compliance Medicaid Fraud and Abuse Reporting Standards policies and procedures are developed using applicable state and federal rules and regulations, and licensing boards from various disciplines as a source. As a contractor or subcontractor of the SBHO, it is the responsibility of the agency to understand and comply with the state and federal regulations that apply to the reporting relationship with the SBHO.

It is also the contractors or subcontractors responsibility to support the SBHO's Compliance Plan, Compliance Committee activities, Compliance Charter, reporting standards, and compliance activities by participating in activities, reporting any suspected violations, and cooperating in any investigation.

The SBHO trainings provide information to encourage employees and contractors to report suspected violations of the SBHO Compliance Plan without fear of retaliation.

The SBHO will provide notification to such law enforcement and regulatory authorities as legal counsel advises, which at a minimum includes, for Medicaid fraud, notification to the Medicaid Fraud Unit of the Washington Attorney General's office and the Office of the Inspector General. The network agency Compliance Plan and staff training must include these outside reporting entities as optional reporting contacts.

Reportage of and Inquiries Regarding Medicaid Fraud and Abuse

SBHO employees, Board and Committee members, network contractors, and individuals have a responsibility to raise questions about business ethics and regulatory compliance, to report incidents of potential noncompliance and to report suspected Medicaid fraud and abuse identified during the course of performing work responsibilities to the Compliance Officer.

A report is made to the Compliance Officer using one of the following options:

1. In person, to the Compliance Officer
2. Faxing a report to the Compliance Officer at (360) 337-5721
3. Anonymously and confidentially calling the Compliance Officer at (360) 337-4648 or (800) 525-5637.
4. Mailing a written concern or report to:

SBHO Compliance Officer (identify as Confidential on outside of envelope)
Salish Behavioral Health Organization
614 Division St. MS 23
Port Orchard, WA 98366

5. Contacting the Washington State Medicaid Fraud Control Unit (MCFU)
   Medicaid Fraud Control Unit of Washington
   Office of the Attorney General
   P.O. Box 40116
   Olympia, WA 98504-0116
   Phone: (360) 586-8888 Fax: (360) 586-8877
   On-line Submission: http://www.atg.wa.gov/MedicaidFraud/default.aspx
6. OIG Hotline 1-800-HHS-TIPS (1-800-447-8477)

SBHO and contractor employees may report any potential fraud or abuse to their agency supervisors or agency designated Compliance Officer who has the responsibility to then report the suspected concerns or misconduct to the SBHO Compliance Officer and MCFU, when appropriate. In addition the PRSN has planned and expects to establish an independent 1-800 fraud or abuse hotline 24/7 to provide optimal opportunity for reporting. Plans include acquisition of posters with information about this independent hotline and that the posters will be posted at key locations at each contractor's site.

The SBHO Compliance Officer (or designee) will maintain a disclosure log and will record each disclosure in the disclosure log within 2 business days of receipt of the disclosure. The log will include a summary of each disclosure received, the status of the respective reviews, and any corrective action taken in response to the internal reviews.
Upon receipt of a disclosure, the SBHO Compliance Officer (or designee) will:

1. Gather all relevant information from the disclosing individual.
2. Make a preliminary good faith inquiry into the allegations set forth in every disclosure to ensure that he/she has obtained all of the necessary information to determine whether a further review should be conducted.
3. Conduct an internal review of allegations set forth in the disclosure and ensure that proper follow-up is conducted for any disclosure that is sufficiently specific so that it reasonably permits a determination of the appropriateness of the alleged improper practice, and provides an opportunity for taking corrective action.

All known reporting persons are advised that they may call back at a later time to receive an update on their reports.

SBHO, Contractor and Subcontractor Business Records
As it was with the PRSN, the SBHO, contractors and subcontractors records will be maintained in a manner that provides for an accurate and auditable account of all financial transactions in conformity with generally accepted accounting principles. All entries must contain an appropriate description of the underlying transaction. All reports, vouchers, bills, invoices, service records, client records, and other essential data must be prepared

with care and honesty. False or deceptive entries related to the expenditure of Medicaid funds are to be reported as possible Medicaid fraud or abuse and investigated. The SBHO will conduct annual fiscal audits to ensure these standards are adequately addressed.

Data and Billing Records

The PRSN has had an ongoing commitment to submitting accurate data and billing records for services that are medically necessary, reflect the services and care provided to clients and are justified by medical record documentation. The SBHO will continue with this same level of commitment regarding data and billing records accuracy. The SBHO, as it was with the PRSN, will consider the following areas those that could potentially rise to the level of constituting Fraud and Abuse. SBHO contractors and subcontractors will be required to report any potential or suspected, such as:

- Duplicate billings
- "Phantom Patients" or enrolling deceased persons
- Failure to identify, pursue and document Third Party resources
- Intentional billing or reporting of services not performed or improper billing
- Unnecessary or misrepresented services
- Billing Medicaid enrollees for SBHO covered services
- Billing for services provided to non-Medicaid individuals
- Upcoding
- Unbundling
- Kickbacks
- Evidence of intentional false or altered documents
- Insufficient documentation to support a recorded service
- Unlicensed or excluded professional or facility at time of service
- Falsification of health care provider credentials or no credentials
- Falsification of agency financial solvency
- Agency management knowledge of fraudulent activity
- Incentives that limit services or referral
- Evidence of irregularities following sanctions for same problem
- Embezzlement and theft

Overpayment is defined as any amount of money SBHO receives in excess of the amount due and payable under any Federal health care program requirements.
If at any time the SBHO identifies any overpayment SBHO will develop a method to address the overpayment to the appropriate payer. If the overpayment is not yet quantified SBHO will notify the payer of effort to quantify the overpayment amount along with a plan of when such work is expected to be completed.

Clinical Documentation
Contractors and subcontractors have contractual responsibility requiring documentation in a client record and to abide by the rules and regulations regarding record maintenance,

record retention, and record confidentiality. These agents have an obligation to ensure required documentation is maintained, kept confidential, and not falsified.

The SBHO conducts annual clinical chart reviews and encounter data validation studies to ensure standards are implemented throughout the region. Clinical documentation standards are routinely discussed in the monthly Utilization Management and Clinical Directors meetings.

Investigations, Corrective Action Plans and Other Responses
All reports of potential violations of laws, regulations, policies or questionable conduct, from any source, will be logged and reviewed by the SBHO Compliance Officer. If after initial investigation and consultation with the SBHO Regional Administrator and Legal Counsel, the Compliance Officer determines there are genuine compliance concerns, the Compliance Officer forwards reports of potential fraud and abuse to MCFU and all other appropriate regulatory authorities.

When an instance of non-compliance has been determined and confirmed, the Compliance Officer (in conjunction with agency management staff) develops or reviews the agency developed initial corrective action plan and develops a report for the Regional Administrator to review.

Upon approval, the Compliance Officer will review and approve the implementation of the corrective action plan, with the advice and guidance of the SBHO Regional Administrator and Legal Counsel. The corrective action plan will focus on implementing changes designed to ensure that the specific violation is addressed and, to the extent possible, improve, prevent or detect any additional compliance inadequacies. The corrective action plan may include one or all of the following areas:

- Specific areas requiring compliance attention
- Requirements of additional training and education
- Further audit and/or investigation
- Disciplinary Action
- Monitoring the results

If the initial investigation reveals possible criminal activity, the corrective action plan includes:

- Immediate cessation of the activity until the corrective action plan is in place.
- Initiation of appropriate disciplinary action against the person or persons involved in the activity.
- Notification to local law enforcement and regulatory authorities as the SBHO Legal Counsel advises, which at a minimum includes for Medicaid Fraud, notification to the Medicaid Fraud Unit of the Washington Attorney General's Office.
- Specific requirements for additional training and education of employees to prevent future similar occurrences.
- Initiation of any necessary action to ensure that no consumers are placed at clinical risk.

Any threat of reprisal against a person who makes a good faith report under the SBHO Compliance Plan is against SBHO policy. Reprisal, if found to be substantiated, is subject to appropriate discipline, up to and including termination.

The SBHO, at the request of a reporting person, will provide such anonymity to the reporting person as is possible under the circumstances in the judgment of the Compliance Officer, consistent with the SBHO's obligation to investigate concerns and take necessary corrective action. Anonymous reporting persons are advised that while they may remain anonymous, the content of their reports is not confidential.

If the identity of the complainant is known, the Compliance Officer provides a written report to the reporting individual that an investigation has been completed and, if appropriate, the corrective action that has been taken.

Risk Assessment. The SBHO will develop and implement an annual risk assessment to identify and address risks associated with regulations and other guidance documents related to policies and procedures. The risk assessment should require compliance, legal and SBHO leaders at least annually to:

a) Identify and prioritize risks
b) Develop internal methods to review work plans related to identified risk areas
c) Review the internal work plans
d) Develop corrective action plans in response to the results of any reviews
e) Track implementation of the corrective action plans in order to assess the effectiveness of SBHO

Policy Violations and Reporting Requirements

SBHO governing board members, QRT members, SBHO Administrator and staff, network contractors and subcontractors must report all suspected, actual or potential violations of the standards and policies outlined in this SBHO Compliance Plan to the SBHO Compliance Officer. Individuals that report incidents must cooperate in all investigations relating to such violations when they have any personal knowledge of the facts. There will be no retaliation against the reporting agency or individuals as a result of such good faith reporting. The SBHO ensures protections against retaliation for individuals that report suspected violations, as outlined in the SBHO Protections Against Retaliation policy.

In the event of an investigation by any state or federal government agency, all parties involved will respond promptly and with complete honesty as requested by the investigators. The SBHO will require that if network entities are contacted by federal or state investigators with regards to the entity's operations, that they immediately notify the SBHO Compliance Officer.

The SBHO Compliance Officer will record all reported suspected violations, and facilitate an investigation in accordance with the SBHO contracts, subcontracts, Medicaid Fraud and Abuse policy and/or other pertinent SBHO policies. The SBHO will prioritize and make reasonable efforts to complete investigations of suspected fraud and abuse reported

to the SBHO in a timely manner and provide documentation of the investigation to the appropriate federal and/ or state authorities.

Disciplinary Guidelines
The PRSN does not and will not employ or contract with providers excluded from participation in federal health care programs. This same expectation applies to the SBHO. If a network provider agency or employee is found to be under investigation for any criminal offense related to health care they are to be removed from direct responsibility for, or involvement with, SBHO funded services.

If a network agency, employee, or officer is listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation, as required by current federal and state laws, or found to have a conviction or sanction related to health care they *will be* excluded from SBHO funding and *will not be* permitted to provide SBHO funded services.

- For a federally excluded network agency, the SBHO will suspend payment, consider terminating the provider contract and may seek repayment of funds. The SBHO will file an investigation through the MCFU hotline.
- For a federally excluded network agency employee, the agency risks not receiving any SBHO funds during the period that the individual is employed. The SBHO will file an investigation through the MCFU hotline.

Currently the PRSN requires network contractors to sign assurances that they are not excluded from participation and do not employ individuals who are excluded. This will be the same when the SBHO is established. The current PRSN requires and the future SBHO will require network contractors to check all newly hired employees against the federal exclusion web sites listed, as follows, prior to hire and monthly thereafter: http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp Each network contractor is and will be expected to attest to the verification. Each month following, supplemental verifications are conducted with written attestation sent to the PRSN/SBHO Compliance Officer.

SBHO Employee Discipline
The SBHO will initiate appropriate disciplinary action against the person(s) whose conduct appears to have been intentional, willfully or reckless with disregard of state and federal laws, in accordance with the County's human resources (personnel) policies and procedures.

Contractor Discipline
The PRSN contracts with network agencies include provisions which require compliance with all state and federal laws and regulations, as well as the PRSN Compliance Plan. The Medicaid revenue contract clearly states that breach of these provisions will be events for corrective action or termination of the contract after failure to cure. The SBHO will also ensure these same provisions will be required of all network agencies.

Network agencies are currently required by the PRSN to report suspicion of employee criminal activity to law enforcement. In addition, network agencies are required to report employee misconduct concerns and inappropriate conduct terminations to Department of Health (credentialing), Child Protective Services, Adult Protective Services, law enforcement, and/or any other associated regulatory entity. The SBHO will require the same of network agencies.

Provider Payment Suspensions

The following provider payment suspension information has not been reflected in detail in the current PRSN policies and procedures. Because of the importance of this information and to ensure clear commitment to Program Integrity the detail information about suspension of provider payment is included in this Program Integrity Plan. This same information will be provided to all behavioral health network providers, in writing and as a part of the Program Integrity training opportunities.

The SBHO will authenticate policies and procedures for suspending a provider's payments when the SBHO determines a credible allegation of fraud exists and there is a pending investigation (42 CFR 455.23).

All suspensions of payment actions under this section will be temporary and will cease after the SBHO or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider or the legal proceedings related to the provider's alleged fraud are completed.

The SBHO must send notice of its suspension of program payments to the provider within the following timeframes:

- Within five business days of taking such action unless requested in writing by the Medicaid Fraud Control Unit (MFCU) or law enforcement agency to temporarily withhold such notice.
- Within thirty calendar days if requested by law enforcement in writing to delay sending such notice. The request for delay may be renewed in writing as many as two times and in no event may the delay exceed 90 calendar days.

The notice of payment suspension must include or address the following:

- State that payment is being suspended in accordance with this provision.
- Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation.
- State that the suspension is for a temporary period and cite the circumstances under which the suspension will be terminated.
- Specify, when applicable, to which type or types of claims or business units of a provider suspension is effective.
- Inform the provider of the right to submit written evidence for consideration by the SBHO.

The SBHO must document in writing the termination of a suspension including, where applicable and appropriate, any Appeal rights available to a provider.

Whenever the SBHO's investigation leads to the initiation of a payment suspension in whole or part, the SBHO must make a fraud referral to the Medicaid Fraud Control Unit (MFCU) and notify DSHS.

The fraud referral must be made in writing and provided to the MFCU no later than the next business day after the suspension is enacted.

If the MFCU or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed.

On a quarterly basis, the SBHO must request a certification from the MFCU or other law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension.

If the MFCU or other law enforcement agency declines to accept the fraud referral for investigation the payment suspension must be discontinued.

A SBHO's decision to exercise the good cause exceptions in this contract not to suspend payments or to suspend payments only in part does not relieve the SBHO of the obligation to refer any credible allegation.

The SBHO may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies implemented by the SBHO more effectively or quickly protect Medicaid funds.
- The SBHO determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.
- Enrollee access to items or services would be jeopardized by a payment suspension because the individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.
- Law enforcement declines to certify that a matter continues to be under investigation.
- The SBHO determines that payment suspension is not in the best interests of the Medicaid program.

The SBHO may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

- Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:
- An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
- The individual or entity serves a large number of Enrollees within a federal HRSA designated medically underserved area.
- The SBHO determines based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
- The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and the SBHO determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
- Law enforcement declines to certify that a matter continues to be under investigation.
- The SBHO determines that payment suspension only in part is in the best interests of the Medicaid program.

The SBHO must meet the following documentation and record retention requirements.

- Maintain for a minimum of five years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including the following:
    - All notices of suspension of payment in whole or part,
    - All fraud referrals to the MFCU or other law enforcement agency,
    - All quarterly certifications of continuing investigation status by law enforcement,
    - All notices documenting the termination of a suspension.
- Maintain for a minimum of five years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause.
- This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the SBHO anticipates such good cause will exist.
    - Annually report to DSHS summary information on each of the following:
        - Suspension of payment, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension.
        - Situations in which the SBHO determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.
        - If the SBHO fails to suspend payments to an entity or individual for which there is a pending investigation of a credible allegation of fraud, without good cause, DSHS may withhold monthly payments.

The SBHO has the option to seek legal and criminal recourse if these disciplinary guidelines are not adhered to.

Training and Education
The SBHO will develop a written training plan that depicts steps the SBHO will take to ensure that all network providers and SBHO staff will receive adequate training regarding the SBHO Program Integrity Program, including Code of Conduct and regulations and guidance documents related to regulations. These guidance documents may include policies and procedures.

SBHO will review the Training Plan annually. When appropriate the Training Plan will be updated to reflect changes in Federal health care program requirements.

SBHO may provide training required under this Program Integrity Plan through appropriate computer-based training approaches.

MONITORING PRACTICES
Fiscal Monitoring
The PRSN currently conducts ongoing, as well as specific fiscal monitoring, in order to detect financial anomalies which may indicate Medicaid fraud or abuse or other illegal activities on the part of network providers. Network providers are required to complete Revenue and Expenditure reports quarterly which are reviewed by the PRSN fiscal staff for inconsistencies. Any inconsistencies are followed up on verbally, and in writing, if verbal clarification was insufficient to explain the inconsistency. The SBHO will implement the same standards.

Programs that are funded with specific line items which are tied to expenditures, such as the Federal Block Grant program, Jail Services program, etc. are monitored on-site at each agency by SBHO fiscal staff, who track reported expenditures to the client level. Providers who have billed for funds to which they were not entitled may be required to re-pay the funds. If the billing inconsistency appears to have been made knowingly by agency management staff, legal counsel will be consulted.

Under the Interlocal Agreement which established the SBHO, Kitsap County is designated as the administrative entity for all SBHO business. As a result, all SBHO fiscal activities are expected to be conducted through the Kitsap County fiscal structure. The County has extensive checks and balances governing its fiscal activities, and is subject to annual audits by the Washington State Auditor. In addition, the Department conducts fiscal monitoring of the SBHO, ensuring that fiscal reports made to the Department of Social and Health Services (DSHS) are accurate and reflective of accounting reports available through the Kitsap county fiscal reporting system.

Resource Management
The PRSN has an extensive history of conducting ongoing and specific monitoring of resource management. The SBHO receives monthly Utilization Management reports

which detail at the agency level how many individuals were authorized for care, and the specific level or type of care for which they were authorized. These reports are reviewed by the Utilization Management Committee (UMC) monthly. The SBHO will continue the monitoring practices as conducted by the PRSN.

Performance statistics for network providers are gathered quarterly by the PRSN. These statistics outline provider performance in terms of numbers of individuals receiving specific modalities of service, crisis service activity, and utilization of facility based programs including community hospital. These statistical reports are reviewed by the Quality Improvement Committee (QUIC), which may request the PRSN to perform additional analysis or garner additional information regarding specific aspects of the reports. It is anticipated that the same practices will be followed by the SBHO.

As required, the SBHO will conduct an analysis of its provider network to ensure compliance with travel standards and network adequacy whenever there are changes in the provider network. Additionally, the SBHO will annually conduct a review of specialists and licensed personnel working within the provider network for adequacy, as well as maintain a directory of bilingual and evidenced-based specialized trained staff available in the network. These tasks are currently conducted by the PRSN and will continue practice will occur by the SBHO.

Utilization Management:
The PRSN currently contracts with an independent contractor, CommCare, to conduct Utilization Management functions. These functions are monitored through a variety of means, including the monthly UMC meetings, in which all network providers as well as CommCare and SBHO staff are involved. The committee reviews all authorization data for anomalies, makes suggestions about additional information which would be useful to review, and serves as a mechanism to share practices and inform the provider network of upcoming practice changes. It is anticipated that the SBHO will continue to contract with CommCare and continue to expect the same type and level of functions to ensure optimal management of services used.

The PRSN has historically conducted at least 500 clinical chart reviews annually. This is a composition of blended comprehensive reviews and targeted reviews, during which clinical files are reviewed to determine if authorization requests are reflective of the clinical need presented in the clinical chart for each case reviewed. Additionally, denials of care are always subject to review. The SBHO will continue to conduct annual clinical chart reviews.

COMPLIANCE PLAN REVIEW
Currently the PRSN Compliance Plan is reviewed by the PRSN Compliance Officer, under the direction of the PRSN Compliance Committee, on an annual basis at minimum and at any other time that to do so would be advantageous to the promotion of ethics and values for the organization, the individuals we serve, family members, and stakeholders. The Compliance Plan will be fortified and reframed as the SBHO Program Integrity Plan upon establishment of the SBHO. Many of the same effective practices, polices, and procedures

found in the PRSN Compliance Plan will be embedded in the SBHO Program Integrity Plan. The parallels with and the augmentations to the existing PRSN Compliance Plan have been identified throughout this Program Integrity Plan.

The SBHO will engage in state required external quality review for independent review.

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Section X: Grievance System Plan

Grievance System—General Requirements **(Question 296)**

The Peninsula Regional Support Network (PRSN), which will become the Salish Behavioral Health Organization (SBHO), has been in existence since 1989, with services beginning in January of 1990. Since 2005, the PRSN has been subject to External Quality Reviews by entities contracted with Washington State to conduct reviews of PIHPs in the State to assess their compliance with the Code of Federal Regulations. Since 2008, the PRSN has scored exceedingly well on the EQRO reviews, only receiving marks below 100% on four subsections of the Grievance review protocol during that entire period.

The Salish BHO will take the PRSN's existing Grievance procedures, and will modify them to include language pertinent to individuals accessing Substance Use Disorder (SUD) treatment services who are our members. These will constitute minor changes, which will allow us to maintain full compliance with CFRs related to Grievances.
The PRSN will conduct a training program for SUD treatment providers which we anticipate contracting with between September 2015 and April of 2016 to ensure that they are fully informed as to the CFR requirements for grievances, and will conduct a review of treatment providers grievance policies prior to entering into contracts with them to ensure their compliance with CFR. Additionally, the PRSN will publish an information poster to be displayed at all contracting agencies informing clientele of their grievance rights under Federal Medicaid law, CFR, RCW, WAC and contract requirements.

The PRSN's existing Policies and Procedures are fully compliant with all contractual, state and federal laws such as the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act. In addition all Federal and state regulations are met in every way herein set forth. PRSN Policies and Procedures devote an entire chapter to this important requirement and are subject to an annual review. If at any time any policy or procedural document is determined to be in need of update, amendment, or deletion the policy or procedure is modified accordingly as soon as possible, even outside the annual review.

The PRSN ensures that its staff and contracted/affiliated providers consistently follow the federal and state laws. The PRSN provides information at the time of contracting to all subcontractors/providers on the grievance system, appeal procedures, and appeal timelines. The PRSN provides information on the availability of assistance in filing and provides a toll-free number that individuals can use to file grievances or appeals. The PRSN does not delegate to providers or subcontractors the adjudication of final appeals. The PRSN has a process to monitor performance of the grievance system.

PRSN demonstrates support/adherence to this CFR in PRSN Policies and Procedures 2.11 (**Exhibit 10a**), 6.06 Grievance Filing Procedure for PRSN for Providers (**Exhibit 47**), 7.06 Utilization Management Plan (**Exhibit 21**), 9.02 Monitoring of Contractors (**Exhibit 16a**), 9.02a PRSN Monitoring Table (**Exhibit 16b**), 9.11 Corrective Action Plans (**Exhibit 49**), 10.01 Quality Management Plan (**Exhibit 13**), 13.01 Mental Health Care Professional

Advocacy (**Exhibit 38**). Additional documentation which illustrates broad communication regarding the grievance system, appeal procedures and appeal timelines can be found in the PRSN Handbook, the CMHA contracts (specifically PIHP Contracts Statement of Work attachment section 11 (pages 25-32); SMHC Contracts Statement of Work section 9 (pages 15-16), the contract with the Ombuds, the contract with CommCare, and the CMHA Administrative reviews. All of the documentation supporting and communicating the clarity of the PRSN grievance process and system is located on the PRSN website.

The PRSN has well established region wide standardized grievance and appeal processes in place for individuals that include a grievance process, an appeal process, and access to the administrative hearings. Throughout the policies and procedures specific to the grievance continuum (PRSN Policies and Procedures 6.01 through 6.08), ancillary policies and procedures, the PRSN Client Rights, Grievance Brochure, PRSN Handbook, contracts, and reporting systems the PRSN consistently presents opportunity for individuals to address concerns. These same processes will become standard for the SBHO.

Throughout the entire grievance process the PRSN endeavors to ensure notice to individuals of their access to State fair hearing for any dissatisfaction eligible for Fair Hearing. Evidence of this dedicated approach is found on page 2 of PRSN Policy and Procedure 6.01 Complaint Grievance Appeal and Fair Hearing General Requirements (**Exhibit 2a**), throughout PRSN Policy and Procedure 6.03 Appeal Process (**Exhibit 5**), throughout PRSN Policy and Procedure 6.02 Grievance (**Exhibit 4**), PRSN Policy and Procedure 6.04 Fair Hearing (**Exhibit 6**), on the Notices of Actions mailed to individuals, and on each acknowledgement letter to those who file a grievance. This same approach will become standard for the SBHO.

The PRSN has and follows a method of monitoring individual rights as reflected in PRSN Policy and Procedure 2.11 (**Exhibit 10a**). The PRSN provides existence, availability, and scope of services regularly and consistently to assist individual's progress to ward recovery and resilience. PRSN information is made available to all individuals on the following topics, through the Department of Social and Health Services (DSHS) Medicaid Benefits Booklet and PRSN produced materials:

- Access to Care
- Covered Title XIX and State Funded Services
- Consumer/Member Service Contact Information
- Provider Network
- Grievance, Appeals and Fair Hearings Rights (42 CFR 431.206)
- Ombuds Program
- Consumer Rights
- Signs of Mental Illness
- Availability of written materials in alternative formats and how to access those formats

ACTIONS

Grievance System—Action **(Question 297)**
Definitions for key terms of art are consistent throughout this Grievance Plan and have been/are used consistently throughout PRSN Policies and Procedures. These definitions are a foundational part of the PRSN grievance process and substantive strategy (42 CFR 400(b)) PRSN Policy and Procedure 6.05 (**Exhibit 7a**). Currently the PRSN defines an Action in the context of Medicaid services as:

- The denial or limited authorization of a requested services, this includes individuals that do not meet Access To Care standards for authorized outpatient services and non-covered services.
- The reduction, suspension, or termination of a previously authorized service that are not mutually agreed upon.
- The denial in whole or in part, of payment for a service.
- The denial of a request for inpatient authorization.
- Disagreement of treatment plan or treatment goals between an individual and provider. This can include medication decisions.
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b), or
- For a resident of a rural area with only one MCO, the denial of an individual's request to exercise his or her right, under section 42 CFR 438.52 (b)(2)(ii), to obtain services outside the network.

SERVICE AUTHORIZATION

The term Service Authorization stems from 42 CFR 438.210(b)(3) for the intent to ensure optimal quality of service. The intent of this regulation is also reflected in the proposed 2016 PIHP contract section 5.1.8 which states "the requirement that any decision to deny a service authorization request to authorize a service in an amount, duration, scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a Chemical Dependency Professional or Mental Health Professional with appropriate clinical expertise".

Grievance System—Service Authorization **(Question 298)**
As the PRSN transitions to become the SBHO the definitions within existing PRSN policies and procedures will be amended to ensure clarity and inclusion of chemical dependency terms and concepts. The term "Service Authorization" will be added. The SBHO will define the term "Service Authorization" as a managed care enrollee's request for the provision of a service.

Grievance System—Service Authorization Process **(Question 299)**
The service authorization process will ensure 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 42 CFR 438.210(b)(3).

NOTICES OF ACTION

The PRSN subcontracted Administrative Service Organization (ASO) is responsible for sending the PRSN NOA letter and conducting the standard and expedited NOA Appeal process. The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process. The ASO may adopt more expansive definitions and procedures to ensure Medicaid recipients/individuals receive more information and notification than required in this policy. The ASO procedure will adhere to Utilization Review Accreditation Commission (URAC) standards.

Grievance System—Notice of Action (NOA) **(Question 300)**

1. The PRSN NOA letter is:
    a. In writing.
    b. In the individual's primary language and to be easily understood.
    c. Explains the action the PRSN or the ASO has taken or intends to take.
    d. Explains the reason of the action.
    e. Provides definitions for reduction, termination, suspension, and denial.
    f. References to the service provision, clinical criteria, guideline, protocol, and/or statue.
    g. Provides information that the specific criteria referenced is available, upon request and free of charge.
    h. Explains the individual's, or the community mental health agency's right to act as an advocate, in filing an Appeal of Action.
    i. Explains the procedures for exercising the individual's rights.
    j. Explains the circumstances under which the expedited resolution is available.
    k. Explains the individual's right to have services continue pending resolution of an appeal, how to request that services be continued, and the circumstances under which the individual may be required to pay the costs of these services; and be mailed as expeditiously as the individual's mental heath condition requires.

(42 CFR438.210(c), 42 CFR 438.404(a-c), 42 CFR 438.10(d) PRSN Policy and Procedure 6.05 (**Exhibit 7a**).
The PRSN provides written materials regarding grievance, appeals and fair hearings in easily understood language and format, including alternative formats, posts client rights in the languages set forth above, provides access to written interpretation of all consumer materials, provides access to these materials prior to conducting an intake evaluation, and maintains a publically accessible internet website. 42 CFR 438.10(c-d); PRSN Policy and

Procedure 2.07 (**Exhibit 11**). In addition to English, the PRSN provides the information described above in the following prevalent languages, upon request:

- Cambodian
- Chinese
- Korean
- Laotian
- Russian
- Spanish
- Vietnamese

All notices of action taken or intended to take include reasons for the action, the individual's or provider's right to file an appeal, the procedures for exercising their rights, the circumstances under which expedited resolution is available and how to request it. In addition each notice of action includes information regarding Individual's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the individual may be required to pay the costs of any services. PRSN Policy and Procedure 6.05 (**Exhibit 7a**).

The PRSN issues and publicizes its hearing procedures in writing to every applicant, including their right to a hearing, the method by which they may obtain a hearing; and that applicant may represent himself or use legal counsel, a relative, a friend, or other spokesman. This information is provided at the time of any action affecting their claim, specifically, it is presented in all Notice of Action letters (42 CFR 431.206; PRSN Policy and Procedure 6.05 (**Exhibit 7a**)).

PRSN has instituted a comprehensive approach to ensuring clear information be presented regarding an opportunity for a hearing if the State agency takes action to suspend, terminate, or reduce services. 42 CFR 431.200(b); 42 CFR 431.220(a)(5). This information is located in PRSN Policies and Procedures 2.07 (**Exhibit 11**), 2.11 (**Exhibit 10a**), 6.01 (**Exhibit 2a**), 6.03 (**Exhibit 5**), 6.04 (**Exhibit 6**), 2.07a the PRSN Member Handbook (**Exhibit 28a**), and can be found in the proposed 2016 PIHP contract section 6.8).

Current policies and procedures do not reflect that an individual must first exhaust all levels of appeals process prior to filing a request for a fair hearing. PRSN Policies and Procedures 6.05 (**Exhibit 7a**), 6.05a (**Exhibit 7b**), 6.05b (**Exhibit 7c**), and 6.05c (**Exhibit 7d**) will be amended to include this before April 2016.

Grievance System—Notice of Action Timeframes—Termination, Suspension or Reduction of Services **(Question 301)**

For utilization management decisions regarding a denial or limit of a request for standard authorization of services the PRSN ASO will mail notice as expeditiously as the individual's health condition requires, not exceeding fourteen days following receipt of the request for services, with a possible extension of up to fourteen additional calendar days if:

a. The individual requesting the services requests an extension, or
b. The network provider or ASO justifies a need for an extension and how the extension is in the person's best interest. PRSN will provide a written notice of the

reason to extend the timeframe and will inform the person of their grievance and appeal rights if they do not agree with the decision.

The PRSN ASO will mail the written notice by priority mail.

The PRSN ASO may determine that following the standard timeframes could seriously jeopardize the life, health, or ability to attain, maintain, or regain maximum functioning of the person making the request. A PRSN ASO must make an authorization decision within three business days after the receipt for request of service.

The PRSN ASO may extend the three day time period by up to fourteen calendar days if the request is made by the person requesting the services, or if the authorization decision and extension is in the person's interest. 42 CFR 404(c); PRSN Policy and Procedure 6.05 (**Exhibit 7a**).

For utilization management decisions regarding denials, termination, suspension, or reduction of previously authorized Medicaid covered services the PRSN ASO will mail notice at least ten days prior to the effective date of action.
For utilization management decisions regarding cases of probable fraud the SBHO may shorten the period of advance notice to five days before the date of the action if there are facts indicating that action should be taken because of probable fraud by the client and the facts have been verified, if possible, through secondary sources PRSN Policy and Procedure 6.05 (**Exhibit 7a**).

In preparing to become an effective BHO the Policy and Procedure 6.05 (**Exhibit 7a**) will be amended to include full language in 42 CFR 431.213 to include

a. The agency has factual information confirming the death of a beneficiary;
b. The agency receives a clear written statement signed by a beneficiary that—
   (1) He no longer wishes services; or
   (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
c. The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;
d. The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);
e. The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
f. A change in the level of medical care is prescribed by the beneficiary's physician;
g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
h. The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

Grievance System—Notice of Action—Timeframes—Denial of Payment **(Question 302)**
For utilization management decisions regarding denial of payment, the notice will be provided at the time of any action effecting the payment 42 CFR 438.404(c)(2); PRSN Policy and Procedure 6.05 (**Exhibit 7a**). For utilization management decisions regarding denials, termination, suspension, or reduction of previously authorized Medicaid covered services the PRSN ASO will mail notice at least ten (10) days prior to the effective date of action.

TIMEFRAMES

Grievance System—Timeframes Denial of Standard Authorization **(Question 303)**
The Peninsula Regional Support Network (PRSN) establishes a standardized process for Medicaid individuals to be notified of denials, intended actions, adverse actions and how to pursue appeals in a manner that gives timely, clear, and easily understood information to persons seeking and receiving publically funded mental health services. 42 CFR 438.210(c); PRSN Policy and Procedure 6.05 (**Exhibit 7a**).

For extensions, the determination is provided as expeditiously as the individual's health condition requires and no later than the date the extension expires. 42 CFR 438.210(d)1; PRSN Policy and Procedure 6.05 (**Exhibit 7a**).

The PRSN ASO may determine that following the standard timeframes could seriously jeopardize the life, health, or ability to attain, maintain, or regain maximum functioning of the person making the request. In such cases, the PRSN ASO must make an authorization decision within three business days after the receipt for request of service. The PRSN ASO may extend the three day time period by up to fourteen calendar days if the request is made by the person requesting the services, or if the authorization decision and extension is in the person's interest. 42 CFR 404(c) 3&4; PRSN Policy and Procedure 6.05 (**Exhibit 7a**).

Grievance System—Timeframes Denial of Expedited Authorization **(Question 304)**
For extensions, the determination will be provided as expeditiously as the individual's health condition requires and no later than the date the extension expires. 42 CFR 438.210(d)2; PRSN Policy and Procedure 6.05 (**Exhibit 7a**).

Grievance System—Timeframes—Untimely Authorizations **(Question 305)**
Service authorization decisions not reached in accordance with the timeframes established per contract constitutes a denial and an Action, which is subject to Appeal. 42 CFR 438.404(c)(5); PRSN Policy and Procedure 6.05 (**Exhibit 7a**). In such cases, a Notice of Action is issued according to NOA procedures.

INFORMATION AND RECORDKEEPING

Grievance System—Information to Providers and Subcontractors **(Question 306)**
The PRSN provides information at the time of contracting to all subcontractors/providers on the grievance system, appeal procedures, and appeal timelines. The PRSN provides information on the availability of assistance in filing and provides a toll-free number that individuals can use to file grievances or appeals. The PRSN does not delegate to providers or subcontractors the adjudication of final appeals.

42 CFR 438.414
PRSN demonstrates support/adherence to 42 CFR 438.414 in PRSN Policies and Procedures 2.11 (**Exhibit 10a**), 6.06 Grievance Filing Procedure for PRSN for Providers (**Exhibit 47**), 7.06 Utilization Management Plan (**Exhibit 21**), 9.02 Monitoring of Contractors (**Exhibit 16a**), 9.02a PRSN Monitoring Table (**Exhibit 16b**), 9.11 Corrective Action Plans (**Exhibit 49**), 10.01 Quality Management Plan (**Exhibit 13**), 13.01 Mental Health Care Professional Advocacy (**Exhibit 38**). Additional documentation which supports ensuring communicating the grievance system, appeal procedures and appeal timelines can be found in the PRSN Handbook, the CMHA contracts (specifically PIHP Contracts Statement of Work attachment section 11 (pages 25-32); SMHC Contracts Statement of Work section 9 (pages 15-16), the contract with the Ombuds, the contract with CommCare, and the CMHA Administrative reviews. All of the documentation supporting and communicating the clarity of the PRSN grievance process and system is located on the PRSN website.

The PRSN's Member Handbook, PRSN Policy and Procedure 2.07 (**Exhibit 28**), given to each Individual at, or soon after intake and when care is reauthorized notifies Individuals of their right to request and obtain names, locations, telephone numbers of and all non-English languages spoken by current network mental health professionals in the Individual's service area. Said handbook and PRSN website inform Individual about how to access specialty care in the network as well as out of network. More specifically the PRSN informs Individual about grievance, appeal, and fair hearing procedures and time frames through the member handbook and from clearly identified information that is sent to the Individual with each letter acknowledging receipt of a grievance. The PRSN provides information to Individual regarding lack of liability for payment for authorized services delivered by insolvent providers. In addition, the PRSN provides each Individual, upon request, information on its structure, operation, and on any provider incentive plans. The PRSN complete structure and operation information can be found on the PRSN website.

42 CFR 438.10(g).

PRSN documentation to support compliance with 42 CFR 438.10(g) consists of PRSN current Policy and Procedures 2.02 (**Exhibit 9**), 2.06 (**Exhibit 3**), 2.07 (**Exhibit 11**), 2.08 (**Exhibit 14**), 2.11 (**Exhibit 10a**), 2.12 (**Exhibit 17**), 6.01 (**Exhibit 2a**), 6.02 (**Exhibit 4**), 6.03 (**Exhibit 5**), 6.04 (**Exhibit 6**), 6.05 (**Exhibit 7a**), 6.05a (**Exhibit 7b**), 6.05b (**Exhibit 7c**), 6.05c (**Exhibit 7d**), 6.07 (**Exhibit 48a**), 6.08 (**Exhibit 8**), 8.01 (**Exhibit 24**), 8.03 (**Exhibit 29**), 8.05 (**Exhibit 30**), 11.03 (**Exhibit 34**), 11.18 (**Exhibit 35**), and 11.20 (**Exhibit 36**). Additional supporting documents include the PRSN Handbook (Policy and Procedure 2.07a), PRSN Grievance Brochure (Policy and Procedure 6.01b), and PRSN website.

Grievance System—Recordkeeping and Reporting **(Question 307)**
42 CFR 438.416 is a recordkeeping and reporting requirement which states that Washington State must require the PRSN to maintain records of grievances and appeals and must review the information as part of the State quality strategy.
Annually the PRSN analyzes trends in grievances and appeals and forwards the results to the QUIC, which uses the information to evaluate potential system improvements. System changes are implemented through staff training and monitored by provider audits. The PRSN has policies and procedures regarding the process of maintaining records on grievances. The PRSN maintains records of Medicaid grievances and appeals, including their resolution for seven years.

PRSN Policies and Procedures 6.07 (**Exhibit 48a**), 6.07a (**Exhibit 48b**), and 6.07b (**Exhibit 48c**) reflect a comprehensive centralized process to ensure maintenance of records of grievances and appeals. PRSN Policy and Procedure 6.07 and 6.08 include a strategy for review of the information to ensure optimal quality. Page 3, Section 4 of PRSN Policy and Procedure 6.07 (**Exhibit 48a**) states "the PRSN Quality Improvement Committee (QUIC) provides the oversight to the grievances, appeal and Fair Hearing filed". The PRSN QUIC reviews the PRSN compiled Grievance and Appeal summary report and forms submitted to the Department". If trends are evident the PRSN QUIC will develop procedural steps to resolve issues. See also PRSN Policy and Procedure 10.01 Quality Management Plan (**Exhibit 13**).

The PRSN contractually requires CMHAs and the Ombuds to provide quarterly grievance tracking reports. All contracts can be found on the PRSN website http://www.kitsapgov.com/hs/Contracts/Mental_Health/MH.htm . In addition, PRSN Policies and Procedures 6.07 (**Exhibit 48a**), 9.02 (**Exhibit 16a**), 9.04 (**Exhibit 33a**), and 9.04c (**Exhibit 33b**) reiterate the contract requirements to submit grievance reports, which will be reviewed by the PRSN QUIC.

The quarterly tracking reports provide system-wide information in a consistent and standardized way. The forms provide the information in aggregate number and nature for Medicaid recipients and non-Medicaid recipients for adult and children's services. Information depicting how the issues were resolved and the timeframes for resolution or disposition, e.g. mediation are reflected in the reports. In addition, the reports tabulate the number of cases that included Ombuds involvement.

APPEAL PROCESS

Grievance System—Appeal **(Question 308)** CFR is definition of action, appeal, grievance Definitions for key terms of art are consistent throughout this Grievance Plan and have been/are used consistently throughout PRSN Policies and Procedures (consider PRSN Policy and Procedure 6.01 (**Exhibit 2a**) Complaint Grievance Appeal and Fair Hearing General Requirements, PRSN Policy and Procedure 6.05 (**Exhibit 7a**) Notice of Action Requirements, and PRSN Policy and Procedure 6.03 (**Exhibit 5**) Appeal Process). These definitions are a foundational part of the PRSN grievance process and substantive strategy. 42 CFR 400(b); PRSN Policy and Procedure 6.05 (**Exhibit 7a**). See also PRSN handbook. The PRSN standardized consumer rights forms are available with readily understandable language. The Washington State Benefits Booklet for People Enrolled in Medicaid is provided to all Individuals. (see CommCare subdelegation contract, Policy and Procedure 6.03 (**Exhibit 5**), 6.05 (**Exhibit 7a**)).

The PRSN has a system, including policies and procedures which informs Individual of their right to access a grievance process, an appeal process, and the state's fair hearing system. Terms specifically defined in this CFR include Action, Appeal, and Grievance. Definitions for these terms can be found in PRSN Policy and Procedure 6.01 (**Exhibit 2a**), 6.02 (**Exhibit 4**), 6.03 (**Exhibit 5**), 6.05 (**Exhibit 7a**), and 6.06 (**Exhibit 47**). Each of these terms can also be found in the Grievance Brochure Policy and Procedure 6.01(b) (**Exhibit 2b**), and in the Notice of Action letters Policy and Procedure 6.05(a), (b), and (c) (**Exhibit 7a**). Definitions with PRSN Policies and Procedures are consistent with 42 CFR 438.400(b).

The PRSN defines grievance as any expression of dissatisfaction by an individual with RSN related services. PRSN Policy and Procedure 6.01 (**Exhibit 2a**), 6.02 (**Exhibit 4**), 6.06 (**Exhibit 47**).

Currently the PRSN defines appeal as a request for review and reconsideration of an action outlined in a written Notice of Action (NOA). There is an expedited appeal process that can be activated. The SBHO will amend current policy and procedures to ensure appeal is defined as an oral or written request by an individual, or with the individual's written permission, the individual's representative, for the regional support network (RSN) to review an "action," as defined in WAC 388-877A-0410(3).

The SBHO policies and procedures will amend the definition of Action to reflect WAC 388-877A-0410(1):

(1) "Action" means, in the case of a regional support network (RSN):
(a) The denial or limited authorization of a requested service, including the type or level of service;
(b) The reduction, suspension, or termination of a previously authorized service;
(c) The denial in whole or in part, of payment for a service;
(d) The failure to provide services in a timely manner, as defined by the state; or

(e) The failure of an RSN or its contracted behavioral health agency to act within the grievance system timeframes as provided in WAC 388-877A-0420 through 388-877A-0450.

Grievance System—Authority to File **(Question 309)**
An individual may file a grievance, an appeal with the PRSN, and may request an administrative fair hearing. A provider, acting on behalf of the individual and with the individual's written consent, may file a grievance, an appeal with the PRSN, and may request an administrative fair hearing. The PRSN adheres to 42 CFR 438.402(b)(1) and WAC388-877A-0420 as represented in PRSN Policies and Procedures 2.07 (**Exhibit 11**), 2.07a (**Exhibit 28a**) 2.07b (**Exhibit 28b**), 2.11and 2.11a (**Exhibit 10a, b**), 6.01 (**Exhibit 2a**), 6.01b (**Exhibit 2b**), 6.02 (**Exhibit 4**), 6.03 (**Exhibit 5**), 6.04 (**Exhibit 6**), 6.05 (**Exhibit 7a**), 6.05a (**Exhibit 7b**), 6.05b (**Exhibit 7c**), 6.05c (**Exhibit 7d**), and in the CMHA contracts.

Grievance System—Timing **(Question 310)**
The PRSN provides opportunity for the Individual to file an appeal in a reasonable timeframe. Medicaid individuals, or their designated advocate, must request an appeal within twenty (20) days of the date on the Notice of Action (noted on the PRSN NOA notification letter). Appeals must be initiated within ten (10) calendar days of the receipt of the PRSN notice for individuals to request that their previously authorized services continue or be reinstated during the appeals process. 42 CFR 438.402(b)(2); PRSN Policies and Procedures 2.07a (**Exhibit 28a**), 2.07b (**Exhibit 28b**), 2.11 (**Exhibit 10a**), 6.01 (**Exhibit 2a**), 6.02 (**Exhibit 4**), 6.03 (**Exhibit 5**), 6.04 (**Exhibit 6**), 6.05 (**Exhibit 7a**), 6.05a (**Exhibit 7b**), 6.05b (**Exhibit 7c**), 6.05c (**Exhibit 7d**), and CMHA contracts.

Grievance System—Appeal Process--Procedures **(Question 311)**
The PRSN has formally adopted policies and procedures related to the PRSN Appeals process for authorization decisions. The PRSN appeals process, subcontracted to and conducted by CommCare, is available to Medicaid individuals for all service denials and non-Medicaid individuals for voluntary inpatient denial decisions. The CommCare appeal process must adhere to PRSN contract and policies, and URAC standards, which align with the Code of Federal Regulations.

An individual may file a grievance, an appeal with the PRSN, and may request an administrative fair hearing. A provider, acting on behalf of the individual and with the individual's written consent, may file a grievance, an appeal with the PRSN, and may request an administrative fair hearing. 42 CFR 438.402(b)(1); WAC388-877A-0420; PRSN Policies and Procedures 2.07 (**Exhibit 11**), 2.07a (**Exhibit 28a**), 2.07b (**Exhibit 28b**), 2.11 and 2.11a(**Exhibit 10a, b**), 6.01 (**Exhibit 2a**), 6.01b (**Exhibit 2b**), 6.02 (**Exhibit 4**), 6.03 (**Exhibit 5**), 6.04 (**Exhibit 6**), 6.05 (**Exhibit 7a**), 6.05a (**Exhibit 7b**), 6.05b (**Exhibit 7c**), 6.05c (**Exhibit 7d**), and in the CMHA contracts.

PRSN Policy and Procedure (**Exhibit 5**) 6.03 establishes a standardized appeal process regarding actions for Medicaid authorization decisions. This policy is designed to outline a

uniform and timely procedure for PRSN appeal process and expedited appeal requirements. The PRSN is the Pre Paid Inpatient Health Plan (PIHP).
The PRSN subcontracted Administrative Service Organization (ASO) is responsible for handling the PRSN the appeals process - standard and expedited. The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process.

The ASO may adopt more expansive definitions and procedures to ensure Medicaid individuals receive more information and notification than required in this policy. The ASO procedure will adhere to URAC/NCQA standards.

The PRSN has a process in place to monitor the resolution and disposition of grievances and appeals to ensure that they meet the required time frames and has a quality improvement process to address noncompliance. In addition PRSN has explicit policies and procedures pertaining to grievances and to standard and expedited appeals PRSN Policies and Procedures 6.01 through 6.08 (**Exhibits 2, 4, 5, 6, 7, 8, 47, 48**).

The PRSN Appeal process is as follows:
Medicaid individuals or providers or representatives on behalf of the individual and with the individual's written permission may request an appeal of action to the PRSN. They may also ask for an expedited appeal. For appeals of the denial of inpatient authorization or extension request, the inpatient provider may also request an appeal or expedited appeal with written permission of the individual seeking services.

Individuals, providers, or other representatives may contact Ombuds services for assistance or may initiate an appeal or expedited appeal verbally or in writing with the PRSN ASO. Ombuds services are available to provide advocacy, assistance, and investigation throughout the appeals process. Ombuds services work to assist individuals or representatives with the standard and expedited appeals process.

A Medicaid individual will receive a written notice of action (NOA) prepared by the PRSN subcontracted Administrative Service Office (ASO) that explains the action the PRSN intends to take or has taken, the reason for the action, and the right to request an appeal or expedited appeal of these actions.

The notice will outline the process to appeal an action. PRSN network providers requesting services on behalf of the individual will also receive notice through the regional Profiler electronic medical record, when the PRAT is authorized.

For denials of inpatient authorization or extension requests the inpatient provider will receive a written notice of action. The PRSN office receives a copy of all notices the ASO provides for 100% review. In addition individuals engaged in services who are in disagreement with a treatment plan or treatment goal are ensured the right to grieve, and potentially appeal any decision about their treatment plan with which they disagree.

Appeals are requests by a Medicaid individual, provider or representative on behalf of the individual and with the individual's written permission to the PRSN for review and reconsideration of an action as outlines in the notice of an action.

For appeals that involve inpatient services, network community mental health agencies, agency provider staff, and inpatient providers may also request an appeal on behalf of the individual, with the individual's written permission.

If the appeal is done verbally, the individual will follow up within seven days of the oral request with a written signed request. CFR 438.402(b)(3)(ii). Oral requests are treated as appeals and therefore establish the earliest possible filing date for appeals 42 CFR 438.406(b) PRSN Policy and Procedure 6.03 (**Exhibit 5**).

The PRSN subcontracted ASO will document any appeal they receive, including the date of receipt, actions taken, resolution offered, and date of notification to the individual. The ASO will attempt to identify the concern at the time of individual contact. The ASO will reiterate the resources, including local Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability, to assist individuals in filing an appeal.

Written requests for appeal should include the name, address, how the PRSN can best contact the individual, reasons for appealing, and any evidence that individual or representatives wish to attach. The individual may send supporting records, letters from their mental health provider, a list identifying qualified witnesses, or other information that explains why services should be provided. Individuals may request information from their mental health provider. The investigation may begin prior to receipt of the written and signed appeal request form.

The PRSN ASO will acknowledge a request for an appeal in writing and begin an investigation within one working day of receipt of a written and signed appeal request (for Standard Reviews).

The written acknowledgement will include notice to the individual or representative that previously authorized services will continue or be reinstated during the appeals process at the individuals or representative's request if:

- The appeal is filed in a timely manner.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were requested by an authorized community mental health agency.
- The individual requests an continuation of services and benefits 42 CFR 438.420(b) PRSN Policy and Procedure 6.03 (**Exhibit 5**)
- The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.

The written acknowledgment will also include notice for any circumstances in which the individual may be asked to pay for the services received during the appeals process if the decision is not in their favor.

The ASO standard appeal process will include:

- Staff involved in the appeal process are/were not involved in previous decision-making of the case, with expertise in the mental health specialty, and whose specialty matches the attending provider's specialty as a clinical peer.
- All outpatient and voluntary inpatient service denials will be reviewed by a certified physician or psychiatrist, who is certified in the relevant clinical specialty (i.e. child and adolescent), was not involved in the previous determination, nor is a subordinate of a previous decision maker.
- Identified review staff may request involvement from the ASO Quality Improvement Committee members. This is at the discretion of the staff member.
- An appeal process will take into account all clinical documents, records, or other information submitted by the individual requesting the appeal, physician, provider, and/or facility relating to the case.
- An appeal process may include contacting the attending provider for additional information and/or clarification of existing information.
- An opportunity for the individual, or their advocate, to review their case file, including medical records and other documents and records considered during the appeal process. 42 CFR 406(b)(3); PRSN Policy and Procedures 6.03 (**Exhibit 5**) and 6.01 (**Exhibit 2a**)
- An opportunity for the individual, or their advocate, to provide written material regarding the stated matter of concern.
- Ensure there are provisions to address retaliation against the individual requesting the Appeal.

Grievance System—Appeal Process—Resolution and Notification **(Question 312)**
For the standard appeal process the ASO must provide the appeal decision within forty-five days from the established filing date. 42 CFR 438.408(b)(2); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

The PRSN ASO may extend the forty-five day timeframe up to fourteen calendar days if:

- The individual provider acting on behalf of the individual requests the extension and there is written agreement.
- The PRSN shows (to the satisfaction of the State, upon its request) that there is a need for additional information and how the delay is in the individual's interest 42 CFR 438.408(b); PRSN Policy and Procedure 6.03.
- Give the individual written notice of the reason for the decision to extend the timeframe and inform the individual (or their designated advocate) of the right to file a grievance, if they disagree with the decision. 42 CFR 438.408(c); PRSN Policy and Procedure 6.01 page 5 (**Exhibit 2a**), 6.03 (**Exhibit 5**), and 6.08 (**Exhibit 8**), 9.02 page 2 (**Exhibit 16a**)
- Issue and carry out the determination as expeditiously as the individual's heath condition requires and no later than the date of the extension expires.

If the issue of dissatisfaction meets the definition for PRSN grievance or the individual is not satisfied with the network provider or subcontractor offered resolution (1st level grievance), the PRSN 2nd level grievance process applies. If the issue is related to a Medicaid authorization determination decision, the PRSN appeal process applies. If the issue is related to extending an authorization decision beyond the standard fourteen days from request, the PRSN ASO will provide the individual a written notice of the reason for the extension and inform the individual of the right to file a grievance if he or she disagrees with that decision 42 CFR 438.408(c); PRSN Policy and Procedure 6.02 (**Exhibit 4**).

For extended authorizations, the determination will be provided as expeditiously as the individual's health condition requires and no later than the date the extension expires.

Grievance System—Appeal Process—Format and Content of Resolution Notice **(Question 313)**

The decision resulting from the standard appeal process will be followed-up and provided in writing. 42 CFR 408(3)(2)(i); PRSN Policy and Procedure 6.03 (**Exhibit 5**). This decision will be provided to the individual, facility (i.e. hospital), and network provider; with a copy sent to the PRSN office. The notice will include:

- The reason for the decision.
- The results of the resolution process and the date it was completed.
- Titles and qualification of all individuals participating in the appeal.
- Reference the plan provision or clinical criteria on which the decision is based.
- Notice that the specific criteria and copies of materials reviewed can be provided free of charge, upon request.
- The support s available if there is any concern of retaliation.
- Information about the right to request an Administrative Fair Hearing and how to do so if the individual believes there's been a violation of the Washington Administrative Code, does not agree to the appeal resolution, or if the PRSN fails to meet the timelines for disposition or extension of the appeal (42 CFR438.408(e); PRSN Policy and Procedure 6.03 (**Exhibit 5**).
- The right to request continued benefits while the hearing is pending and how to make the request; and notice that the individual may be responsible for the costs of those continued benefits if the hearing decisions upholds the original action. 42 CFR 438.408(e); PRSN Policy and Procedure 6.03 (**Exhibit 5**).
- For denied service decisions resolved in favor of the individual, information about how to the individual may obtain services, support available to assist in obtaining service, and information that individuals must initiate services within sixty (60) days.

The ASO will have formal procedures for utilization action decisions that are upheld or reversed, including written notification to the individual, the network provider, PRSN and other entities involved.

APPEAL AND FAIR HEARING PROCESS

Grievance System—Appeal and State Fair Hearing Process—Continuation of Benefits **(Question 314)**

Medicaid individual, or their designated advocate, must request an appeal within twenty days of the date on the service denial (noted on the PRSN NOA notification letter). 42 CFR 438.402(b)(2); PRSN Policy and Procedure 6.05 (**Exhibit 7a**). Appeals must be initiated within ten calendar days of the receipt of the PRSN notice for individuals to request that their previously authorized services continue or be reinstated during the appeals process.

The PRSN ASO will acknowledge a request for an appeal in writing and begin an investigation within one working day of receipt of a written and signed appeal request (for Standard Reviews). The written acknowledgement will include notice to the individual or representative that previously authorized services will continue or be reinstated during the appeals process at the individuals or representative's request if:

- The appeal is filed in a timely manner.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were requested by an authorized community mental health agency.
- The individual requests an continuation of services and benefits. 42 CFR 438.420(b); PRSN Policy and Procedure 6.03 (**Exhibit 5**).
- The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.

The written acknowledgment will also include notice for any circumstances in which the individual may be asked to pay for the services received during the appeals process if the decision is not in their favor.

Any written notice of the decision on the appeal will include the right to request continued benefits while the hearing is pending and how to make the request; and notice that the individual may be responsible for the costs of those continued benefits if the hearing decision upholds the original action which was adverse to the individual 42 CFR 438.420(b); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

The PRSN will continue the individual's services/benefits (42 CFR 438.420(b); PRSN Policy and Procedure 6.03 (**Exhibit 5**)) if all of the following apply:

1. The individual or the provider files the appeal on or before the later of the following:
    - Within ten calendar days of receipt of the PRSN notice, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three calendar days of the intended effective date of the PRSN ASO proposed action
    - The intended effective date of the PRSN proposed action

2. The appeal involves the denial or requested services, termination, suspension, or reduction of a previously authorized course of treatment.
3. Services were requested by an authorized community mental health agency
4. The individual requests a continuation of services and benefits, and
5. The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.

If, at the individual's request, the PRSN ASO continues and reinstates the individual's services while the appeal is pending, (42 CFR 438.420(c); PRSN Policy and Procedure 6.03 (**Exhibit 5**)) the services must be continued until one of the following occurs:

1. The individual withdraws the appeal.
2. Ten days pass after the PRSN mails notice of disposition of an appeal and the resolution is not in favor of the individual, unless the individual requests a Fair Hearing (with continuation of services Fair Hearing decision is reached), or
3. The Office of Administrative Hearings issues a Fair Hearing decision adverse to the individual.

Individuals who request continuation of benefits will be notified that if the final resolution of the appeal is adverse to the individual. The PRSN may request the individual to reimburse the cost of the services furnished to the individual while the appeal was pending.

If the PRSN fails to meet the timelines concerning any appeal, they will provide the services that are the subject of the appeal. The PRSN will pay the community mental health agency to provide these services.

If the final resolution of the appeal upholds the PRSN ASO action, the regional support network may recover the amount paid for the services provided to the individual while the appeal was pending, to the extent that they ere provided solely because of the requirement for the continuation of services and in accordance with 42 CFR 431.230; 42 CFR 431.420(d); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

If the state Fair Hearing officer upholds the PRSN appeal ruling/ action, the PRSN may recover the amount paid for the services provided to the individual while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services and in accordance with 42 CFR 431.230; 42 CFR 431.420(d); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

Grievance System—Appeal and State Fair Hearing Process—Effectuation when Services were not Furnished (**Question 315)**
If the PRSN ASO or the state Administrative Hearing Office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PRSN or ASO will authorize and the community mental health agency will provide the disputed services promptly, as expeditiously as the individual's mental health condition requires. 42 CFR 438.424(a); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

Grievance System—Appeal and State Fair Hearing Process—Effectuation when Services were Furnished **(Question 316)**
If the PRSN ASO or the state Administrative Hearing Office reverses a decision to deny authorization of services, and the individual received the disputed services while the appeal was pending, the PRSN must pay for those services 42 CFR 438.424(b); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

If the final resolution of the appeal upholds the PRSN ASO action, the regional support network may recover the amount paid for the services provided to the individual while the appeal was pending, to the extent that they ere provided solely because of the requirement for the continuation of services and in accordance with 42 CFR 431.230; 42 CFR 438.424(b); and 42 CFR 431.420(d); PRSN Policy and Procedure 6.03 (**Exhibit 5**) and 6.05 (**Exhibit 7a**).

EXPEDITED APPEALS

Grievance System—Expedited Appeals Process—General **(Question 317)**
The PRSN follows the expedited appeal process outlined below when an expedited appeal is requested by an individual or representative and the PRSN ASO determines that taking the time for a standard resolution could seriously jeopardize the individual's life, mental heath or ability to attain, maintain, or regain maximum function 42 CFR 438.410(a); PRSN Policy and Procedure 6.03 (**Exhibit 5**). The PRSN also follows the expedited appeal process when a network provider or inpatient facility indicates that the individual's condition requires a more immediate response and that taking the time for a standard resolution could seriously jeopardize the individual's quality of life like, mental heath or ability to attain, maintain, or regain maximum function.
Medicaid individuals or their representative may also request an expedited Fair Hearing when the individual or representative believes that taking the time for standard resolution would jeopardize the individual ability to maintain or regain maximum functioning 42 CFR 438.410(a); PRSN Policy and Procedure 6.04 (**Exhibit 6**).

Grievance System—Expedited Appeals Process—Authority to File **(Question 318)**
The expedited appeal process will meet the additional requirement that requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the individual or representative 42 CFR 438.402(b)(3)(ii); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

Grievance System—Expedited Appeals Process—Procedures **(Question 319)**
The PRSN provides the individual or their designated advocate an opportunity to present evidence, and allegations of fact in person, as well as in writing, and inform the individual of the limited time available for expedited resolution. 42 CFR 438.406(b)(2); WAC 399-877A-0440(4)(a); PRSN Policy and Procedure 6.02 (**Exhibit 4**).

Grievance System—Expedited Appeals Process—Resolution and Notification **(Question 320)**
The PRSN grievance process is typically resolved within thirty days, but not to exceed ninety days, inclusive of established filling date (and agency offered solution). The PRSN will attempt to resolve the grievance quickly and to the individual's satisfaction. The resolution will be resolved as expeditiously as the individual's mental health condition requires. 42 CFR 438.408(a); WAC 833-8771-0420(5)(d); PRSN Policy and Procedure 6.02 (**Exhibit 4**).

The PRSN expedites the grievance process when an individual's condition requires a more immediate response to a grievance. Expedited appeals may be requested when the individual, provider or other representative believe that taking the time for a standard resolution could seriously jeopardize the individual's life, mental health or ability to attain, maintain, or regain maximum functioning 42 CFR 438.408(a); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

When the individual or their advocate requests an expedited resolution of a grievance, the PRSN must respond within three working days or sooner based on medical necessity of the individual. Requests for expedited resolution may be initiated orally or in writing. The PRSN will make a grievance review and determination, with offered resolution, as expeditiously as the individual's mental health condition requires within three working days or sooner based upon the medical necessity of the individual. 42 CFR 438.408(b); PRSN Policy and Procedure 6.02 (**Exhibit 4**).

Expedited appeals may be requested when the individual, provider or other representative believe that taking the time for a standard resolution could seriously jeopardize the individual's life, mental health or ability to attain, maintain, or regain maximum functioning. 42 CFR 438.408(a); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

The same appeals rules, policies, and processes apply to appeals on NOAs. When the appeal is in regards to a NOA the ASO will comply with the aforementioned 42 CFR 438.408(a-b) as noted in PRSN Policy and Procedure 6.03 (**Exhibit 5**). The PRSN ASO will make a decision on the individual's request for expedited appeal and provide notice, as expeditiously as the individual's mental health condition requires, within three (3) working days, as established by 42 CFR 438.408(b)(2); WAC 388-877A-0440(7)(b)(ii); PRSN Policy and Procedure 6.03 (**Exhibit 5**) or sooner based on the medical necessity of the individual 42 CFR 438.408(a); PRSN Policy and Procedure 6.03 (**Exhibit 5**). The PRSN ASO will also make reasonable efforts to provide oral notice. 42 CFR 438.408(d)(2)(ii); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

If the PRSN ASO denies a request for an expedited resolution of an appeal, it will transfer the appeal to the timeframe for a standard resolution; and make reasonable efforts to give individual prompt oral notice of the denial, followed up with two (2) calendar days with a written notice, and inform the individual of their right to file a grievance regarding the denial of expediency. 42 CFR 438.408(d)(2)(ii); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

Grievance System—Expedited Appeals Process—Punitive Action **(Question 321)**
The PRSN ensures that retaliation or punitive action is not taken against an individual who requests an expedited resolution 42 CFR 438.410(b); PRSN Policy and Procedure 6.02 (**Exhibit 4**), and Policy and Procedure 2.22 Protection Against Retaliation (**Exhibit 23**).

The PRSN ASO, also, ensures that retaliation or punitive action is not taken against an individual or provider who requests an expedited resolution or supports an individual's appeal. 42 CFR 438.410(b); PRSN Policy and Procedure 6.03 (**Exhibit 5**), Policy and Procedure 2.22 Protection Against Retaliation (**Exhibit 23**).

STATE FAIR HEARING PROCESS

Grievance System—State Fair Hearing Process—Notification of State Procedures **(Question 322)**
The PRSN provides information at the time of contracting to all subcontractors/providers on the grievance system, appeal procedures, and appeal timelines. The PRSN provides information on the availability of assistance in filing and provides a toll-free number that individuals can use to file grievances or appeals. The PRSN does not delegate to providers or subcontractors the adjudication of final appeals. The PRSN has a process to monitor performance of the grievance system and has a QA/PI corrective action plan to respond to any findings. 42 CFR 438.414

PRSN demonstrates support/adherence to this CFR in PRSN Policies and Procedures 2.11 (**Exhibit 10a**), 6.06 Grievance Filing Procedure for PRSN for Providers (**Exhibit 47**), 7.06 Utilization Management Plan (**Exhibit 21**), 9.02 Monitoring of Contractors (**Exhibit 16a**), 9.02a PRSN Monitoring Table (**Exhibit 16b**), 9.11 Corrective Action Plans (**Exhibit 49**), 10.01 Quality Management Plan (**Exhibit 13**), 13.01 Mental Health Care Professional Advocacy (**Exhibit 38**).

Additional documentation which supports ensuring communicating the grievance system, appeal procedures and appeal timelines can be found in the PRSN Handbook, the CMHA contracts (specifically PIHP Contracts Statement of Work attachment section 11 (pages 25-32); SMHC Contracts Statement of Work section 9 (pages 15-16), the contract with the Ombuds, the contract with CommCare, and the CMHA Administrative reviews. All of the documentation supporting and communicating the clarity of the PRSN grievance process and system is located on the PRSN website. 42 CFR 438.414.

The PRSN or its contracted provider provides the information to Individuals regarding grievance, appeal, and fair hearing procedures and timeframes. 42 CFR 438.400 through 42 CFR 438.424. The aforementioned procedures and timeframes include descriptions for

- State fair hearing,
- Individual rights to file grievances and appeals,
- the requirements and timeframes for filing a grievance or appeal,
- the availability of assistance in the filing process,
- the toll-free numbers that the Individual can use to file a grievance or appeal,
- that benefits will continue if the Individual files and appeal or request a fair hearing within specified timeframes ,
- that the individual may be required to pay costs of services while the appeal is pending if the final decision is adverse to the individual, and
- any appeal rights that the State chooses to make available to providers to challenge the failure of het organization to cover a services. 42 CFR 438.10(g)(1)

42 CFR 438.10(g).

Grievance System—State Fair Hearing—Parties **(Question 323)**

For Fair Hearings that involve appeals, parties to the Fair Hearing include the PRSN and the subcontracted ASO, the individual and their advocate (this may include but is not limited to family, friend, Ombuds, mental health primary care provider, mental health agency, or inpatient facility), or the estate representative of a deceased individual 42 CFR 438.408(f)(2). PRSN Policy and Procedure 6.04 Page 4 Monitoring # 1 (**Exhibit 6**).

OTHER GRIEVANCE QUESTIONS

Grievance System—Grievance—Definition **(Question 324)**

PRSN provides definitions to ensure agencies and the federal government use terms consistently. The PRSN has a system, including policies and procedures which informs Individual of their right to access a grievance process, an appeal process, and the state's fair hearing system. Terms specifically defined in this CFR include Action, Appeal, and Grievance. Definitions for these terms can be found in PRSN Policy and Procedure 6.01, 6.02, 6.03, 6.05, and 6.06. Each of these terms can also be found in the Grievance Brochure (Policy and Procedure 6.01(b) (**Exhibit 2b**), and in the Notice of Action letters (Policy and Procedure 6.05(a) (**Exhibit 7b**), (b) (**Exhibit 7c**), and (c) (**Exhibit 7d**)). Definitions with PRSN Policies and Procedures are consistent with 42

CFR 438.400(b).
The PRSN defines grievance as any expression of dissatisfaction by an individual with RSN related services (PRSN Policy and Procedure 6.01 (**Exhibit 2a**), 6.02 (**Exhibit 4**), 6.06 (**Exhibit 47**). Filing grievances should be a common standard practice at the provider agency and PRSN level; and not described to individuals in any way that discourages the process. It is expected that the network provider agencies and PRSN will encourage and support an individual using the formalized grievance system.

- 1st level grievances are filed by an individual at the provider level.
- 2nd level grievances are filed by the individual at the PRSN level, either as an initial grievance or filed as a result of dissatisfaction with the 1st level grievance.

Issues of dissatisfaction that are filed by ancillary systems or unauthorized family member are resolved outside the formal grievance system. Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the PRSN appeal process.

Grievance System—Grievance Process—Procedures and Authority to File (**Question 325**)
The PRSN supports the filing of grievances either orally or in writing with the PRSN or with the behavioral health agency, as evidenced in several policies and procedures. Specifically, Policy and Procedures 6.01 page 2 (**Exhibit 2a**), and 6.02 page 2 (**Exhibit 4**), first paragraph states "Filing grievances should be a common standard practice at the provider agency and PRSN level; and not described to individuals in any way that discourages the process. It is expected that the network provider agencies and PRSN will encourage and support an individual using the formalized grievance system". Encouraging an open and transparent practice reflects an understanding that grievances promote the need to constantly examine and improve business practices.

42 CFR 438.402(b)(3)(i); WAC 388-877A-0420.
The PRSN adheres to 42 CFR 438.402(b)(1) and WAC388-877A-0420 as represented in PRSN Policies and Procedures 2.07 (**Exhibit 11**), 2.07a (**Exhibit 28**a), 2.07b (**Exhibit 28**b), 2.11 and 2.11a (**Exhibit 10a**), 6.01 (**Exhibit 2a**), 6.01b (**Exhibit 2b**), 6.02 (**Exhibit 4**), 6.03 (**Exhibit 5**), 6.04 (**Exhibit 6**), 6.05 (**Exhibit 7**), 6.05a (**Exhibit 7b**), 6.05b (**Exhibit 7c**), 6.05c (**Exhibit 7d**), and in the CMHA contracts. An individual may file a grievance, an appeal with the PRSN, and may request an administrative fair hearing. A provider, acting on behalf of the individual and with the individual's written consent, may file a grievance, an appeal with the PRSN, and may request an administrative fair hearing.

PRSN Grievance Policies and procedures are designed to allow individuals and/or advocates/representatives the opportunity to have a grievances heard in a uniform manner and resolved in a timely fashion. They outline the rights, responsibilities and requirements of the PRSN, consumers, providers, and other involved parties at all levels of the grievance, appeal, and fair hearing system 42 CFR 438.402(b)(1)(i); PRSN Policy and Procedure 6.02 (**Exhibit 4**) and 6.01(**Exhibit 2a**).

Grievance System—Grievance Process—Disposition and Notification **(Question 326)**
A standard grievance process is typically resolved within thirty (30) days, but not to exceed ninety (90) days, inclusive of established filling date and offered solution. The PRSN will attempt to resolve the grievance quickly and to the individual's satisfaction. The resolution will be resolved as expeditiously as the individual's mental health condition requires 42 CFR 438.408(b)(1); WAC 833-8771-0420(5)(d); PRSN Policy and Procedure 6.02 (**Exhibit 4**).

Expedited appeals may be requested when the individual, provider or other representative believe that taking the time for a standard resolution could seriously jeopardize the individual's life, mental health or ability to attain, maintain, or regain maximum functioning. 42 CFR 438.408(a); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

The PRSN ASO will make a decision on the individual's request for expedited appeal and provide notice, as expeditiously as the individual's mental health condition requires, within three (3) working days, as established by 42 CFR 438.408(b)(2); WAC 388-877A-0440(7)(b)(ii); PRSN Policy and Procedure 6.03 (**Exhibit 5**) or sooner based on the medical necessity of the individual 42 CFR 438.408(a); PRSN Policy and Procedure 6.03 (**Exhibit 5**). The PRSN ASO will also make reasonable efforts to provide oral notice. 42 CFR 438.408(d)(2)(ii); PRSN Policy and Procedure 6.03 (**Exhibit 5**).

Conclusion

As previously mentioned, the PRSN's current Policies and Procedures comply fully with all laws, state and federal. These same Policies and Procedures are fully compliant with contract requirements and federal and state regulations. As the PRSN transitions to becoming the SBHO the current Policies and Procedures will be scrutinized and modified to include language for individuals seeking and engaging in SUD treatment services. We anticipate these changes to be minor but necessary to ensure full compliance with all laws, regulations, and contractual obligations.

As the PRSN moves toward becoming the SBHO, training will be vital to ensure that the SUD treatment providers understand grievances as per the contract, the CFR requirements, and the grievance Policies and Procedures. Support for the SUD treatment providers will be provided by the PRSN/SBHO to assist with understanding and implementing the requirements. Meetings, consultations, and reviews will be some of the methods used to provide the training and support.

Second Opinions **(Question 274)**
SBHO provides second opinions from qualified healthcare professionals at contracted BHAs within the SBHO service area. If a qualified healthcare professional is not available within the SBHO network, SBHO arranges for the enrollee to obtain a second opinion outside of the network, at no cost to the enrollee. All second opinions must occur within 30 calendar days of the request. PRSN policy will be updated to include second opinion rights for those receiving SUD treatment as well.

Out of Network Services **(Question 275)**
When a SBHO contracted network provider is unable to provide a medically necessary service to a Medicaid recipient, substance abuse or mental health related, the provider arranges and pays for such services to be delivered in a timely manner. PRSN policy will be updated to include second opinion rights for those receiving SUD treatment as well.

Section XI: Tribal Coordination and Communication Plan

Tribes represent a strong and important presence in the SBHO, and are integral to our communities. There are seven Tribes within the SBHO region, the Hoh, Quileute, Makah, Lower Elwha Kallam, Jamestown S'Klallam, Port Gamble S'Klallam, and Suquamish. The Interlocal Agreement establishing the SBHO includes a Tribal representative on the Executive Board of the SBHO, which has been the case for the Peninsula Regional Support Network for a number of years. In establishing the Interlocal Agreement, a decision was made to include two at-large positions on the SBHO Advisory Board for Tribal delegates.

Six of the Tribes have strong well established wellness programs that include Behavioral Health services, and the Lower Elwha Klallam Tribes' Substance Use Disorder program in Port Angeles is the largest outpatient SUD program in our Region.

The Peninsula RSN has been meeting with Tribes for many years on a regular basis, and the SBHO will continue to do so, with regular meetings presently scheduled for twice a year. The five Tribes located in Jefferson and Clallam Counties have participated in a 7.01 planning day the last several years, and the SBHO will continue to participate in that event should it continue.

The SBHO has met with all but one of the Tribes in our Region to develop Crisis Agreements, and we have successfully agreed to mechanisms to be utilized to respond to mental health crisis on Tribal land or involving Tribal members, though no agreements have been formally signed.

Tribes have been briefed on the development of the SBHO, encouraged to appoint members to the Advisory Board, and the Jamestown S'Klallam Tribe is a signator to the Interlocal Agreement establishing the SBHO.

Inclusion of Tribal Authorization—Roles and Responsibilities (**Question 169**)
In 2009, the PRSN was approached by the Jamestown S'Klallam Tribe which requested to become a part of the Interlocal Agrement and have a seat on the Executive Board of the PRSN. An Interlocal was negotiated that included the Tribe, and the same format has been utilized in the creation of the Salish Behavioral Health Organization, which includes an elected official from the Jamestown S'Klallam Tribe on the Executive Board. In addition, the new Interlocal establishing the SBHO also designates two seats on the SBHO Advisory Board as at-large seats to be occupied by Tribal members in compliance with RCW 71.24.300 (2).

In creating contracts with Tribes for the provision of direct services as a BHO, the SBHO will incorporate language included in the Model QHP Addendum for Indian Health Care Providers as applicable. The PRSN currently has small contracts with six of the tribes

located within our Region, and it is the plan for the SBHO to continue this long – standing practice.

The SBHO will continue to focus on equitable access for behavioral health services for those from the AI/AN community. We will utilize demographic reports from our data system to measure the penetration of our services into the AI/AN community, and implement corrective action measures if it appears that the AI/AN community is under-represented in our service delivery for either mental health or substance use disorder services. We will use our semiannual meetings with Tribes to discuss access issues, and address any concerns voiced in those meetings.

Culturally competent service delivery is an underpinning of the services provided through the SBHO. The SBHO will recruit consultants from each Tribe's wellness program to add to the list of specialists which the SBO keeps updated annually. Providers in the SBHO will be required to consult with Tribal consultants whenever providing services to an individual from that Tribe. The SBHO will establish a policy that will require network agencies to consult with Tribal wellness programs whenever a Tribal member is accessing behavioral health services unless the individual objects to such contact and coordination being made.

All but one of the Tribes in the SBHO has a vigorous Wellness Program, and it is anticipated that most Tribal court orders for Substance Use Disorder Treatment will be to these programs. The SBHO will work with Tribal programs to create a seamless mechanism for Tribal Wellness programs to access SUD residential programs as well as to coordinate care for those Involuntarily detained for substance use disorders when those services are necessary. The SBHO will continue to provide sufficient oversight of the services provided to ensure that they are Medically Necessary.

The PRSN has a long history of coordinating with Tribal programs, and is committed to continuing this policy as we become the Salish Behavioral health Organization. The region will continue to contract with Tribes to fund tribally defined wellness projects, and the SBHO will meet with Tribes at least twice per year, and with whatever frequency is necessary to coordinate care effectively for Tribal populations. Current agreements with the Tribes are included as **Exhibit 22**.

Section XII: Evidenced Based, Research Based and Promising Practices Analysis and Development Plan

This section is no longer required per communication from DSHS.

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Section XIII: Behavioral Health Data Consolidation Project Plan

This section address SBHO's overall data consolidation plan and **Question 295**, Health Information Systems, and is a response to Behavioral Health Data Consolidation Requirements, Exhibit A.

1) **Provide your plan and timeline to collect and report on the data elements contained in Table 1 (Non-Provider One data elements) and Table 2 (Provider One data elements).**

On 09/02/2015 we received the BHDC Data Dictionary with this update:

This document in addition to the revised Service Encounter Reporting Instructions (SERI), which is due out for public comment November 1, will replace the data elements that are currently identified in the Request For Detailed Plans.

Using the 09/02/2015 Draft BHDC Dictionary as the guide, all Non-ProviderOne data elements will be collected directly from providers within 30 days after close of the month of service. Providers will use a secure FTP site to upload these transactions in a tab-delimited format to the BHO. Our system will import and process this data into our SQL database on a nightly basis. Any errors are sent back to the provider for correction due within 14 days.

Non-ProviderOne data elements are sent on a weekly schedule to DHBR using their secure Tumbleweed FTP site.

ProviderOne data elements will be collected directly from providers within 30 days after close of the month of service. Providers will use a secure FTP site to upload these transactions in EDI format to the BHO. Our system will import and process this data into our SQL database on a nightly basis and any errors are sent back to the provider for correction due within 14 days. Providers have been informed that services over a year old will not be accepted without special exception.

These records are sent on a weekly schedule to ProviderOne using a secure FTP. Shortly after uploading, ProviderOne sends an ACK file to confirm that submitted files have been accepted into their system. All ACK files are kept by the BHO for future reference. Once a week the ETRR files are downloaded from ProviderOne and any service errors are sent to the providers for correction and resubmission.

Once the BHDC Dictionary and SERI are finalized, we will be able to update our data tables and set up our system for demographic and EDI file testing. The final BHDC Dictionary is tentatively scheduled for release on 10/01/2016 and we will send that to our providers as soon as we receive it. Once provider EMRs are updated, we will be able to initiate demographic testing for each site as early as December or January. The SERI publish date is 02/01/2016 and we will ask providers to contact us as soon as their EMR is

updated so we can start testing service files as soon as possible and troubleshoot any issues.

Our system will be ready to receive and process production data on 04/01/2016.

2) **Describe your plan to assess and ensure the provider agencies in your network (or subcontractors) are able to submit client and service data that meets the BHO reporting requirements (as specified in table below).**

   a. **Describe any barriers your substance use disorder treatment agencies have in meeting the data collection and transmission requirements?**

After discussions with the administrators of the SUD facilities it is apparent that they do not have the budget for expensive EMR solutions. Also, they do not have the staffing for extreme IT infrastructure upgrades and we have recommended they consult with an IT company to ensure their operating systems are up to date and any unsupported programs replaced with newer, supported options.

The SUD sites not using Target for data entry are using Avail Health Notes (http://availhealth.com/avail-health-notes.html) and the company owner has confirmed that the company is ready for the upcoming data changes in April and will be able to send us the data in the formats we require. Once the state has finalized the data elements in the Data Dictionary and the Service Encounter Reporting Guide we will notify each provider and supply them with the reference guides. The providers are responsible for scheduling updates of their software and once that is complete we will start testing to confirm data integrity before sending any data to the state.

One of the sites presently not using an EMR is considering Avail Health as the best option due to cost ($2000 to purchase, $75 per user per month). The other sites not currently using this product are still researching possibilities.

   b. **How are your communicating the data reporting requirements?**

We have been communicating upcoming changes using email, phone and provider site meetings with SUD agencies. A summary of data requirements was pulled from the draft contract and distributed to providers to clearly state the changes and expectations. Monthly meetings with SUD providers are taking place to keep them updated on the progress of the BHO transition and the data requirements. Any changes to the data reporting requirements will be sent out to all SUD contacts as soon as we receive them.

   c. **Describe technical assistance or other support you are providing to substance use disorder treatment agencies?**

With the agencies using Avail Health we have been able to contact the company directly to confirm that their agency is capable of submitting the data as required. The SUD providers contacted that are not using any software other than Target are county-based and we have contacted their IT departments to make them aware of changes that they will need to make in their collection systems. We have also recommended that all SUD sites review their IT systems with either their internal IT staff or a consulting agency.

d. Describe the IT systems/EHRs used by the provider agencies in your network to collect and submit client and services information?

At this time the only EHR used by SUD providers is Avail Health Notes (http://availhealth.com/avail-health-notes.html). Other sites log directly into Target for their data entry and they have been notified that they need to find a new solution.

3) Document your plan to collect client and services data from the substance use residential providers located throughout the state?

When the Data Dictionary and SERI are finalized, they will be sent to the SUD providers. There will be an extensive testing period where multiple demographic and service files will be tested for each site.

Once the sites are ready, all client and service data will be directly submitted by providers to the BHO using a secure FTP site. All sites will get one-on-one training that will walk them through the whole process of uploading and how to access error reports.

4) Document your systems capacity to collect, store, and submit funding source information associated with a person and service, in order to meet block grant reporting requirements.

Our system capacity will be monitored by county IT staff and expanded as needed. Providers will be able to submit demographic and service data at any time of the day and all data is submitted once a week to the State and ProviderOne.

All data elements required for the SUD block grant are collected as mandated by the BHDS Data Dictionary for BHOs.

Providers are responsible for tracking funding for their clients and this will be reviewed during SBHO yearly fiscal audits.

5) Describe how will you ensure that encounters are submitted within 30 days after the close of the month of service?

Providers will be required by contract to send data within 30 days after close of month of service for both demographic and service data. Providers can securely drop off files at any time of the day using secure FTP and data will import and process on a nightly basis. If a file fails import an automatic message will be sent to both the provider and the IS Manager. This allows for timely action to correct any issues.

Reports on timeliness will be run every month to confirm that sites are submitting in a within contract parameters. Timeliness is also monitored through Administrative reviews. Any provider performing below expected standards may require a Corrective Action Plan.

SBHO Detailed Plan
Exhibit List

Exhibit number	Exhibit Name
1	List of Planned Substance Abuse Disorder Treatment Providers
2	PRSN Policy 6.01 Grievance Appeal **and** 6.01b Fair Hearing Gen Req and Brochure
3	PRSN Policy 2.06 Comprehensive Information Plan
4	PRSN Policy 6.02 Grievance
5	PRSN Policy 6.03 Appeal Process
6	PRSN Policy 6.04 Fair Hearing
7	PRSN Policy 6.05 Notice of Action Requirements, 6.05a NOA Form Letter, PRSN Policy 6.05b NOA Ineligible Form Letter, 6.05c NOA Tx Plan Form Letter
8	PRSN Policy 6.08 Grievance Reporting Instructions
9	PRSN Policy 2.02 Advance Directives
10	PRSN Policy 2.11 Enrollee Rights Policy, 2.11a Enrolle Rights English
11	PRSN Policy 2.07 General Information Requirements
12	PRSN Policy 2.14 Interpreter Services and Assistance
13	SBHO Policy 10.01 Quality Management Plan
14	PRSN Policy 2.08 PRSN Rehabilitative and Integrated MH Treatment
15	Sample Clinical Reviews
16	PRSN Policy 9.02 Monitoring of Contractors and 9.02a Monitoring Table
17	PRSN Policy 2.12 Consent for Treatment
18	SBHO Policy 10.04 Quality Indicators
19	SBHO Policy 11.15 Use of Evidence Based Practices
20	PRSN Policy 7.03 Mental Health Level of Care Guidelines
21	PRSN Policy 7.06 Utilization Management Plan
22	Example Contracts with Tribes in the SBHO Region
23	PRSN Policy 2.22 Protections Against Retaliations
24	PRSN Policy 8.01 Enrollee Liability for Payment
25	Recent QRT Review
26	Sample Chart Review Tools
27	PRSN Policy 2.06 Comprehensive Information Plan
28	PRSN Policy 2.07a and 2.07b PRSN Member Handbooks, English and Spanish
29	PRSN Policy 8.03 Third Party Liability & Coordination of Benefits
30	PRSN Policy 8.05 Fiscal Monitoring
31	BHO Interlocal Agreement (Draft)
32	Pre Delegation Review Tool (Draft)
33	PRSN Policy 9.04 Subcontractual Delegation & Assessment and 9.04c Items of Delegation
34	PRSN Policy 11.03 Service Modalities Outpatient
35	PRSN Policy 11.18 Primary Care Provider & Hospital ER Coordination
36	PRSN Policy 11.20 Special Healthcare Needs - Services & Coodination
37	Sample 2015 Agency Administrative Reviews

SBHO Detailed Plan
Exhibit List

Exhibit number	Exhibit Name
38	PRSN Policy 13.01 Mental Healthcare Professional Advocacy
39	Sample Fiscal Monitoring Reports
40	2015 Encounter Data Validation
41	PRSN Policy 12.06 Admission and Discharge Coordination
42	PRSN Policty 12.02 Voluntary Inpatient Gatekeeping
43	Quaility Improvement Committee July Mailing
44	PRSN Org Chart **and** Draft SBHO Org Chart
45	PRSN Policy 12.09 Childrens Long Term Inptatient Program and 12.09a Clip Admission Procedure
46	Sample Agreements with City and County Jails
47	PRSN Policy 6.06 Grievance Filing Procedure for PRSN for Providers
48	PRSN Policy 6.07 Grievance Oversight and Recordkeeping, 6.07a Quarterly Agency Medicaid Tracking Form, 6.07b Quarterly Agency non-Medicaid Tracking Form
49	9.11 Corrective Action Plans
50	SBHO Policy 11.25 Uniform Inpatient and Outpatient Inter-BHO Transfer Protocol **and** 11.25a Inter-BHO Transfer Agreement Form

PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: GRIEVANCE, APPEAL AND FAIR HEARING GENERAL REQUIREMENTS **Policy Number:** 6.01

Reference: 42 CFR 438.400; WAC 388-865-0255; PIHP and SMHC Contract

Effective Date: 6/2005

Revision Date(s): 9/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: Grievance Reporting Forms (Medicaid , non-Medicaid, and Appeal)
- Policy: Appeal Process
- Policy: Grievance
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Notice Of Action Requirements
- Policy: Grievance Oversight and Recordkeeping

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a process for both Medicaid enrollees and state funded individuals to pursue a grievance, appeal, and access an Administrative Fair Hearing.

This policy is designed to allow individuals and/or advocates/representatives the opportunity to have grievances heard in a uniform manner and resolved in a timely fashion.

The PRSN policy will outline the rights, responsibilities and requirements of the PRSN, consumers, providers, and other involved parties at all levels of the grievance, appeal, and fair hearing system.

This policy applies to Medicaid enrollees and state funded individuals receiving services paid for by the PRSN. The PRSN is the Pre-Paid Inpatient Health Plan (PIHP).

DEFINITIONS

A Grievance is any expression of dissatisfaction by an individual with RSN related services. Filing grievances should be a common standard practice at the provider agency and PRSN level; and not described to individuals in any way that discourages the process. It is expected that the network provider agencies and PRSN will encourage and support an individual using the formalized grievance system.

- 1st level grievances are filed by an individual at the provider level.
- 2nd level grievances are filed by the individual at the PRSN level, either as an initial grievance or filed as a result of dissatisfaction with the 1st level grievance.

Issues of dissatisfaction that are filed by ancillary systems or unauthorized family member are resolved outside the formal grievance system. Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

Appeal means a request for review and reconsideration of an action outlined in a written Notice of Action (NOA). There is an expedited appeal process that can be activated.

An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested services, this includes individuals that do not meet Access To Care standards for authorized outpatient services and non-covered services.
- The reduction, suspension, or termination of a previously authorized service that are not mutually agreed upon.
- The denial in whole or in part, of payment for a service.
- The denial of a request for inpatient authorization.
- Disagreement of treatment plan or treatment goals between an individual and provider. This can include medication decisions.
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b), or
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network.

Administrative Fair Hearing means a hearing conducted through the auspices of the state Office of Administrative Hearings in accordance with Washington Administrative Code (WAC) 388-02. An issue of dissatisfaction must complete the PRSN Grievance/and Grievance Appeal process prior to requesting a DSHS Administrative Fair Hearings.

- The term Fair Hearing is synonymous with Administrative Hearing.

An Individual is defined as a person meeting the criteria for a consumer under WAC 388-865-0150, or a Medicaid enrollee. This definition includes parents of a child under 13 years who is receiving services or a parent of a child under 18 years who is involved the treatment team.

Mental Health Care Provider means an individual with primary responsibility for implementing an individualized service plan for mental health services.

Provider means any PRSN contracted network community mental health agency licensed to provide mental health services covered in the PRSN contracts (PIHP and SMHC). Community Mental Health Agency is synonymous with provider.

PROCEDURE

1. The PRSN values the resolution of grievances and appeals at the local/ lowest possible level, in a confidential manner and without retaliation.

   Retaliation, formal or informal, against an individual or a mental health agency will not occur by developing a multi-level and independent grievance system.
   - There will be no retaliation or punitive action of any kind against an individual who initiates a grievance, appeal or request for fair hearing.
   - There will be no retaliation against a provider, or providers, that initiate a grievance or appeal on behalf of an individual.

2. All offered resolutions to complaints and grievances honor individual voice, choice, and rights of and on behalf of the individual filing the concern. Ensure that at all stages of the process emphasis shall be placed on a consumer-defined solution.
   - Resolutions will consider the most effective clinical practices, Access to Care Standards, medical necessity, laws and federal, state and contractual requirements.

3. Individuals, and their designated advocates, may initiate and pursue a complaint, grievance, appeal and fair hearing.
   - Grievances can be filed orally. A grievance form is provided as an option to assist in defining the issue(s) of concern and requested resolution.
   - Appeals can be filed either orally or in writing. A written, signed request must be submitted within seven (7) days of an initial oral request. The oral filing may be used to establish the earliest filing date.
   - For Medicaid enrollees, previously authorized services will continue or be reinstated during the grievance process at the individual's request. During appeals, previously authorized services may continue or be reinstated under certain circumstances.

When grievances or appeals are not resolved wholly in favor of the individual, under certain circumstances they may be asked to pay for these services.

- Filed grievances, and appeals will be investigated even if the individual is no longer receiving services.

4. The PRSN will ensure that individual's are made aware that at any point in the process they may utilize an advocate or representative to assist them (with written permission), such as:
    - A community mental health agency, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal, or
    - A community mental health agency may file a grievance, appeal or request a state fair hearing on behalf of an enrollee and act as the enrollee's authorized representative.
    - At a minimum, Ombuds services will be offered at all levels of the process.
    - Reasonable assistance shall be provided in completing forms and taking other procedural steps. This may include providing interpreter services and toll-free numbers that have adequate TTY/TTD capability.

5. Individuals may request an appeal of an action by the PRSN or its formal designee. Appeals regarding authorization decisions by PRSN are pursued with CommCare.

    Individuals will receive a written notice of action that outlines their rights to appeal actions including service determination or authorization by the PRSN designee, CommCare, and the process to appeal these actions with the PRSN.

    - Outpatient and inpatient actions, for Medicaid individuals, can be pursued through the appeal process.

6. A request for a Fair Hearing may be made at anytime a consumer, or their designated advocate, believes there has been a violation of the Washington Administrative Code (WAC). A Fair Hearing may also be requested if they are dissatisfied with the PRSN resolution of a grievance or appeal.
    - Ensure that at no time does this procedure cancel the individual's right to request a Fair Hearing.

7. The PRSN informs individuals of their rights to initiate a grievance (including expedited grievances), appeal, and fair hearing through distributing published DSHS Benefit Booklet, PRSN brochures, Ombuds material, PRSN handbook and PRSN standardized consumer rights forms with readily understandable language.

    The DSHS Benefit Booklet is mailed to Medicaid recipients annually from the state.

The PRSN brochures are available in public areas throughout the community, posted on the PRSN website, and mailed upon request . The PRSN handbook is mailed to all individuals authorized and re-authorized for care within the network, at least annually.

The PRSN standardized outpatient client rights form is provided along with consent for treatment and grievance information. The rights are also listed in the DSHS Benefits booklet, Ombuds brochure and PRSN brochure and handbook.

- This information shall be made available to all current and potential users of publicly funded mental health services, and advocates in language that is clear and easily understood to the individual.

- The individual filing the grievance, or appeal (or their designated advocate) may examine their case file, including medical records, documents and records considered at any time before and during the grievance appeal process.

8. The PRSN, network providers and subcontractors will cooperate with and promptly abide by all grievance, appeal, and Fair Hearing decisions. The PRSN will require this in contracts and will monitor compliance with this requirement through the annual administrative review process.

9. The PRSN and network providers maintain records of grievances, appeals, and Fair Hearings. All records will be retained for six (6) years following a resolution.
    - All records of grievances, appeals, and Fair Hearings will be kept confidential and separate from clinical records. These records will not be disclosed without the individual's written authorization, except as necessary, in the following circumstances:
        i. to resolve the issue(s) of concern
        ii. to DSHS if a Fair Hearing is requested
        iii. or for review as part of the quality improvement or state quality strategy

MONITORING

1. This policy will be monitored through PRSN:
    - Review and approval of network providers Grievance policies
    - Annual network provider and subcontractor Administrative Reviews
    - PRSN Trainings
    - PRSN Grievance Tracking Reports. Information about individual grievances, appeals, or Fair Hearings that have system wide implications may be used for quality improvement.

- Quality Management Plan activities, such as standard review of the Grievance Tracking forms and report, analysis of targeted trends and system recommendations. Information about types of agency or PRSN grievances, PRSN appeals, Fair Hearing requests and denials will be used to analyze patterns or trends and identify areas for quality improvement.
- The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.

2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for PRSN approval.

Authorized PRSN Community Mental Health Providers

Crisis services are available 24 hours a day, 7 days a week. For non-crisis hours of operation, please contact the individual Mental Health Provider at its local number.

East Clallam County

Peninsula Behavioral Health
118 East 8th Street
Port Angeles, WA 98362
360-457-0431 Services
360-452-4500 Crisis

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West Clallam County

Forks Community Hospital – West End Outreach Services
530 Bogachiel Way
Forks, WA 98331
360-374-6177 (Services or **Crisis**)

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Jefferson County

Jefferson Mental Health Services
884 W Park
Port Townsend, WA 98368
360-385-0321 or 877-410-4803 (Services or **Crisis**)

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Kitsap County

Kitsap Mental Health Services
5455 Almira Drive NE
Bremerton, WA 98311-8330
360-373-5031 TDD 360-478-2715
Emergency Services 360-373-3425
Crisis Clinic 360-479-3033 or 800-843-4793
From North Kitsap 360-535-5400
From Bainbridge Island 206-694-4655

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PRSN Administration Offices
614 Division Street, MS-23
Port Orchard, WA 98366-4676
360-337-4604 FAX 360-337-5721
Toll Free 1-800-525-5637

Peninsula Regional Support Network

Community Mental Health Services in Clallam, Jefferson & Kitsap Counties

Complaint, Grievance, & Fair Hearing Brochure

September 2013

Administered by the Kitsap County Department of Human Services

If you have a concern about the quality of your mental health services or access to services, you have the right to file an agency or Peninsula Regional Support Network (PRSN) Grievance or Fair Hearing.

By sharing your concerns, problems are resolved and we can ensure improvement to the overall system.

Ombuds Services are offered at no cost to assist individuals who have questions or need assistance with filing a Grievance or Fair Hearing.

PRSN Ombuds Services

BRIDGES Mental Health Ombuds

9004 Washington Ave NW

Silverdale, WA 98383

(360) 692-1582 or

1-888- 377-8174

ombuds@kitsapdrc.org

All calls are kept confidential and support client-directed solutions.

It is a good idea to try to resolve your concerns with the person directly involved or ask the Ombuds to assist you.

- Explain your concern. Be clear about what an acceptable solution will be.
- Try to find ways to reach agreement that will satisfy both you and the other person.

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What is a Grievance?

A Grievance is any issue of dissatisfaction with some aspect of service. Grievances can be filed with the network mental health agency or the PRSN office.

- 1st level Grievance refers to issues filed with an agency.
- 2nd level Grievance refers to issues filed with the PRSN office.

How do I file a Grievance?

A Grievance may be filed orally or in writing. You can file your concern in person, by telephone or in writing.

You may file the concern or an authorized representative may file the concern for you.

Typically, Grievances about direct services are filed with your mental health agency. These are referred to as 1st level Grievances.

If you are not satisfied with the offered resolution, you can file a 2nd level Grievance with the PRSN office.

You also have the option of initially filing your concern directly with the PRSN office.

Peninsula Regional Support Network

614 Division Street MS-23

Port Orchard, WA 98366-4676

(360) 337-4604 or

1-800-525-5637

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What happens after I file a Grievance?

Every agency and PRSN Grievance is acknowledged in writing. The letter explains what actions will be taken to resolve your concern.

A written resolution is typically provided within 30 days from the filing date, however the required timeframe is within 90 days.

Can I continue to receive services while my Grievance is in process?

Yes, your mental health services will continue through your authorization period. Contact the PRSN immediately if you feel your services have been affected as a result of sharing your concern.

What if I am not satisfied with the offered resolution?

If you are not satisfied with the offered resolution to your 1st level Grievance, you can file a 2nd level Grievance.

If you are not satisfied with the offered resolution to the 2nd level Grievance, you have the right to file a Fair Hearing request with:

What is a Fair Hearing?

A Fair Hearing is an expression of dissatisfaction, after filing a PRSN Grievance.

Fair Hearings are filed with the Department of Social & Health Services (DSHS) Office of Administrative Hearings.

DSHS Office of Administrative Hearings

1-800-583-8271

September 2013

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PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: COMPREHENSIVE INFORMATION PLAN FOR PRSN DELIVERY SYSTEM AND SERVICES

Policy Number: 2.06

Reference: DSHS Contract, WAC 388-865-0221, -0330; 42 CFR 438.100(b) (2&3)

Effective Date: 9/2005

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: General Information Requirements
- PRSN Member Handbook

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to plan and implement actions which ensure to the extent possible, individuals eligible for mental health services are notified of the existence, availability, and services within the PRSN. In part, the PRSN and/or the network providers or subcontractors will advise Medicaid and non-Medicaid individuals eligible for mental health services about their rights, promote access to individuals who are of limited proficiency in English, encourage stigma reduction activities and support recovery and resiliency.

INFORMATION PLAN

The Peninsula Regional Support Network (PRSN) is committed to developing and utilizing a comprehensive information plan that includes benefit information, services available, how to access services, enrollee rights and responsibilities, and accommodations available for diverse populations (including other languages than English) within the region. The PRSN and/or the providers will incorporate use of media, stigma reduction activities, and plan for ongoing evaluation of the strategic

information plan. The information plan includes the following areas that are addressed on an ongoing basis:

DSHS Benefit Booklet

1. The PRSN will provide the Department the information necessary to update the Department of Social and Health Services (DSHS) Benefits Booklet for Medicaid enrollees.

2. The PRSN and the network providers will provide a copy or access to the electronic version of the DSHS Benefit Booklet produced by the Department to Medicaid enrollees receiving services. The written booklet will be provided at any time, upon enrollee request.
    - The DSHS Benefits Booklet (electronic version) is also listed on the PRSN website.

3. The booklet serves as a mechanism to inform enrollees of their benefits, rights, and responsibilities.

4. The booklet can be downloaded from: http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml

PRSN Service Description

1. The PRSN has designed a member handbook. It contains the following information:
    - A brief overview of the PRSN values, function, and service delivery model.
    - Core network provider names, addresses, and phone numbers.
    - A description of Medicaid/non-Medicaid covered services and how to access them. Recipient's responsibility when attempting to access out of the area services, including a statement about what constitutes out of the area services.
    - A brief description of Ombuds, parent advocacy, and NAMI advocacy resources.
    - PRSN office contact information.
    - How to file a network agency and PRSN grievance, and DSHS fair hearing.
    - How to access the handbook in alternative/translated formats and cultural service delivery considerations.

2. The PRSN website makes general information easily accessible. The current PRSN mission, brochure, handbook, and manual are listed,

- The PRSN website is located at http://www.kitsapgov.com/hr/wsolympic/prsn/prsnmain.htm

Consumer Notification of Rights, Responsibilities, and Grievance

Distribution of Information

The Washington State Department of Social and Health Services (DSHS) distributes an enrollee benefits handout to Medicaid individuals at the time of enrollment. This booklet provides individuals general information about rights, access, crisis information, and the Regional Support Network system.

The PRSN and/or the providers provide information to individuals eligible for mental health services by distributing informational material at a wide variety of locations accessed on a regular basis by individuals who may qualify for services. Providers also have the information available to handout prior and during an intake assessment. Provider brochures will be located in various publicly accessible and conspicuous office locations, as will brochures describing the function of the Ombuds program.

The PRSN informational material as described above includes:

1. Information advising individuals eligible for mental health services of their rights and responsibilities. When contractually required, the network providers and subcontractors will have the rights conspicuously posted in lobby areas in the DSHS designated seven languages.

2. Information advising individuals eligible for mental health services of their right to file grievance procedures with Ombuds assistance, the right to express dissatisfaction with services at the provider and PRSN level, as well as the DSHS Fair Hearing processes. Information will inform individuals that Ombuds support is available when pursuing grievances and fair hearings. The Ombuds toll free number will be listed.

Access to Mental Health Services

Telephone Directory

The PRSN, the network providers and subcontractors, including the Ombuds, will maintain telephone number listings and identification of service, in all major area telephone directories, including a toll free number and crisis line access numbers.

Internet Website Directory

The PRSN maintains a website that provides links to all our core network provider homepages.

The PRSN website also provides direct links to the PRSN Consumer Handbook, State Benefits Booklet, PRSN Grievance brochure, and Advance Directive information.

Area Resource Directories

The PRSN, the network providers and subcontractors, including the Ombuds, will refer individuals to the local 211 for listing of services and telephone numbers for commonly used services in the local area.

Services for Diverse Populations

The PRSN network providers and subcontractors are required to provide interpreter services for enrollees with a primary language other than English for all interactions between the individual and the network provider/subcontractor, including, but not limited to: customer service, all appointments for any covered service, crisis services, and all steps necessary to file a grievance or appeal.

DSHS Targeted Diverse Populations

The Washington State DSHS benefits booklet is sent to Medicaid individuals at the time of enrollment. The benefits booklet can be downloaded in the targeted languages through the http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml website.

1. The PRSN will provide translated information on access to care, Medicaid and non-Medicaid covered services, member contact information for provider network, Ombuds program and description and contact information, PRSN office contact information, consumer rights, and how to access the material in alternative formats (such as Braille and large print).

2. DSHS has targeted the following seven languages for rights to be posted and all written PRSN informational material (as listed above) to be translated into:
   - Cambodian
   - Chinese
   - Korean
   - Laotian
   - Russian
   - Spanish
   - Vietnamese

3. Information on how to access written material in an alternative language must be provided prior to conducting an intake evaluation.

PRSN Additional Targeted Diverse Populations

The PRSN distributes Performance reports to each provider and the Quality Improvement Committee quarterly. The y review reports illustrate the percentage of diverse populations served and compares it to current census information within each provider catchment area. The reports are used to calculate other diverse population than recognized by DSHS within our catchment area and evaluate if the diverse populations within the area are underserved. When an underserved population is identified, the PRSN and the providers develop strategies to improve access for that group.

Network Provider Service Descriptions

Brochures

The PRSN requires the network providers, subcontractors, and Ombuds to:

1. Publish their own informational brochure listing address, phone, and services specific to their individual agency.

2. Publish brochures in English. The brochures will be published in Spanish and Tagalog in areas where there is a population of 500 or greater (per census information), whose primary language is Spanish or Tagalog located within the provider's catchment area. As additional primary languages are identified for a census population of 500 or greater, the brochures will be published and distributed in those areas.

3. Distribute the brochures as described above.

Notices

1. The PRSN requires the providers, subcontractors, and Ombuds to:
    - Make bulletin boards and other adequate space available for posting information, legal notices, hours of operation, services and service locations, benefit opportunities, grievance procedures, interpretive or other special population rights, notifications, and other contractual material that may be useful for the consumer population and general public.
    - Post notices, rights, advocacy groups and grievance information prominently.

2. The PRSN provides Notice of Action (NOA) written notification to Medicaid enrollees for intended authorization decisions that meet the definition for an action. All NOA material is accompanied with information about the PRSN Appeal process.

3. The PRSN provides written notification to individuals stating the disposition of a grievance and resolution of an appeal filed with the PRSN.

4. The PRSN provides written notification to non-Medicaid individuals seeking outpatient services through the PRSN and *do not* meet entrance criteria.

Written Materials

The PRSN network providers, subcontractors, and Ombuds will give each consumer written materials available in English or other alternate languages, as defined above in the DSHS targeted and PRSN additional targeted diverse populations, which include:

1. A statement of services provided by the agency or organization, and how to access.

2. Consumer rights and responsibilities.

3. Agency/PRSN grievance procedures, including how to file a concerns at various levels (such as through the provider, Ombuds, PRSN, and a state administrative hearing through the Department).

4. Ombuds Services.

5. HIPPA Privacy Statements.

6. Signs of mental illness.

7. How to request information in another format/language.

Media

The PRSN and/or the provider network will utilize various forms of the media to provide PRSN mental health service information:

1. Inform the public about services available for individuals with mental illness, including information about statewide access criteria.

2. Notify the public regarding upcoming events, speakers, workshops, conferences, support groups and the meetings of the local and National Alliance for the Mentally Ill (NAMI).

3. Reduce stigma by providing informational articles/videos, regarding mental illness, recovery, and services.

4. Information may also be distributed through other postings or programs including through radio spots, speakers bureaus accessing service clubs, newspapers,

newsletters, magazines, posters, billboards, flyers, internet website postings and any other means deemed useful.

Ancillary and Allied Cross System Information Sharing

The PRSN, network providers, and subcontractors are committed to building partnerships with social service providers across the region to share information and coordinate services to meet the needs of individuals with mental illness.

1. The PRSN, network providers, and subcontractors will encourage allied providers to distribute our informational materials that publicize mental health services, rights, educational/anti-stigma campaigns and accompanying information.

2. The PRSN is committed to informing the allied systems of services, upcoming events, workshops, and trainings, and resources in the community to support the treatment of individuals with mental or emotional disturbances.

3. The PRSN is committed to establishing and maintaining working agreements with allied systems. Reference the PRSN Cross System Working Agreements.

PRSN Information Plan Evaluation

The PRSN will review and evaluate this plan on an annual basis to assess the following:

1. Using the provider quarterly performance reports, to determine if information reaching the designated populations and locations.

2. Have other organizations or services been developed that we need to target with information on mental illness and services to the mentally ill?
   - In 2012 with 211, the requirements for a local resource directories at each network agency was deleted.

3. Using 2010 or more current census data, determine if the information need to be translated in any other language to meet the need of any specific population in the area.

PRSN PLAN MONITORING

The PRSN Comprehensive Information Plan is mandated by federal and state statue and contract.

1. This plan will be reviewed, and updated, at least annually.

2. This plan will be monitored through use of the PRSN:
    - Monthly Ombuds Activity Reports
    - Annual PRSN Provider and Subcontractor Administrative Review
    - Biennial Provider Quality Review Team On-site Review
    - Grievance Tracking Reports

2. Any area of the plan not meeting plan expectations, the PRSN shall implement a Corrective Action Plan. Reference PRSN Corrective Action Plan Policy.

PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: GRIEVANCES **Policy Number:** 6.02

Reference: 42 CFR 438.214;WAC 388-865-0255; PIHP and SMHC Contract

Effective Date: 8/2004

Revision Date(s): 12/2014

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Appeal Process
- Policy: Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Grievance Oversight and Recordkeeping
- Policy: Notice Of Action Requirements

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a process for both Medicaid enrollees and state funded individuals to pursue a grievance (including expedited grievance) requirements.

This policy is designed to allow individuals and/or advocates/representatives the opportunity to have a grievances heard in a uniform manner and resolved in a timely fashion.

The PRSN policy will outline the rights, responsibilities and requirements of the PRSN, consumers, providers, and other involved parties at all levels of the grievance, appeal, and fair hearing system.

This policy applies to Medicaid enrollees and state funded individuals receiving services paid for by the PRSN. The PRSN is the Pre-Paid Inpatient Health Plan (PIHP).

DEFINITIONS

A Grievance is any expression of dissatisfaction by an individual with RSN related services. Filing grievances should be a common standard practice at the provider agency and PRSN level; and not described to individuals in any way that discourages the process. It is expected that the network provider agencies and PRSN will encourage and support an individual using the formalized grievance system.

- 1st level grievances are filed by an individual at the provider level.
- 2nd level grievances are filed by the individual at the PRSN level, either as an initial grievance or filed as a result of dissatisfaction with the 1st level grievance.

Issues of dissatisfaction that are filed by ancillary systems or unauthorized family member are resolved outside the formal grievance system. Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

An Individual is defined as a person meeting the criteria for a consumer under WAC 388-865-0150, or a Medicaid enrollee. This definition includes parents of a child under 13 years who is receiving services or a parent of a child under 18 years who is involved the treatment team.

PROCEDURE

1. The PRSN will ensure Ombuds services and assistance is available to provide advocacy, assistance, and investigation to individuals with concerns, family members and other interested parties throughout the grievance process.
    - Ombuds work to assist in resolving the issue at the lowest level possible.
2. For all grievances, individuals with concerns may have representation of their choice involved throughout the process(es). This may include, but is not limited to Ombuds, family members, mental health care professional, network provider, and network mental health agency.
3. For Medicaid enrollees, individuals filing an agency or PRSN grievance will be notified that previously authorized services will continue or be reinstated during the process at the individual's (or their advocates) request.
4. Individuals or their advocates may examine case files, including medical records and any other documentation considered during the and grievance process (before and during).
5. Qualified mental health care professionals who have the appropriate clinical expertise will participate in the grievance resolution process(es).

a. Staff with the authority to resolve the issue(s) of concern or require corrective action will participate in the process and offer a face to face meeting as needed to resolve the issue(s).

6. A grievance must have occurred within the past 6 years. Clinical documents are required to be retained for 6 years. PRSN can attempt to investigate a grievance older than 6 years; however, documentation retention may restrict the ability to thoroughly investigate.

Network Agency Grievance Process: 1st Level

The network provider agency grievance is referred to as a 1st level grievance.

1. The PRSN will provide information about the grievance system to all network providers and subcontractors at the time they enter into a contract with the PRSN. Revisions to contract requirements or implementation changes will be presented to the network providers prior to implementation.

2. The PRSN will insert into each network provider and service contract the condition to abide by all grievance, appeal and administrative hearing decisions.

3. If the issue of dissatisfaction is defined as an agency grievance, the network provider agency will have a process that includes:

   a. An agency single point of contact.

   b. A standard process that typically is resolved within thirty (30) days, but not to exceed ninety (90) days, inclusive of established filling date (and agency offered solution.

      - Grievances can be filed orally or in writing.
      - The network agency will attempt to resolve the grievance quickly and to the individual's satisfaction. The resolution shall be resolved as expeditiously as the individual's mental health condition requires.
      - Assistance will be provided to the individual and Ombuds services will be offered.

   c. An agency will acknowledge receipt of the verbal or written grievance within five (5) days of receipt.

   d. The agency offered resolution shall be provided in writing. The written response will include the reason for the decision, the right to pursue a PRSN grievance, the right for previously authorized services to continue or be reinstated during the grievance process at the individual's request,

and the process and available supports if the individual (or their advocate) has any additional concerns about retaliation.

- If the individuals is not satisfied with the agency offered solution(s), a process to forward and begin the PRSN grievance process within one (1) working day.

4. The PRSN will send a Notice of Action to the individual about their rights to request a Fair Hearing if the agency or PRSN fails to meet the ninety (90) day timeline to the disposition of the grievance.

5. Agency grievances will be documented and tracked for continuous quality improvement regardless of the resolution.

   - Issues of concern filed by allied systems, advocates, unauthorized family members or other parties will be documented outside of the grievance system.

PRSN Grievance Process: 2nd Level

The PRSN grievance is referred to as a 2nd level grievance.

1. If the issue of dissatisfaction meets the definition for PRSN grievance or the individual is not satisfied with the network provider or subcontractor offered resolution (1st level grievance), the PRSN 2nd level grievance process applies.

   - If the issue is related to a Medicaid authorization determination decision, the PRSN appeal process applies.
   - If the issue is related to extending an authorization decision beyond the standard fourteen (14) days from request, the PRSN ASO will provide the individual a written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

     For extended authorizations, the determination will be provided as expeditiously as the individual's health condition requires and no later than the date the extension expires.

2. The PRSN grievance process is typically resolved within thirty (30) days, but not to exceed ninety (90) days, inclusive of established filling date (and agency offered solution.

   - The PRSN will attempt to resolve the grievance quickly and to the individual's satisfaction. The resolution shall be resolved as expeditiously as the individual's mental health condition requires.

3. The PRSN will acknowledge receipt of a formal grievance in writing within five (5) working days.

Oral or written fillings are accepted. The PRSN has an optional Grievance form that may assist an individual in defining the issues of concern, as well as the requested resolution.

- For Medicaid enrollees, the written acknowledgement will include notice to the designated advocate that previously authorized services will continue or be reinstated during the grievance process at the individual's(or their advocates) request and circumstances in the individual may be asked to pay for the cost of those benefits if the grievance upholds the original decision.
- A copy of the written acknowledgement will be provided to the involved network provider agency and Ombuds.

3. If the individual is dissatisfied with the results of the PRSN Grievance process, they may under circumstances request additional consideration of the formal review, referred to as a Fair hearing, from the state through the Office of Administrative Hearings.
   - An individual has the right to file a Fair Hearing request about a Grievance issue without utilizing the PRSN grievance process.

PRSN Standard Grievance Process (not expedited)

1. The individual, and their designated advocate, will be provided assistance with the grievance process. If the individual or their advocate is not receiving assistance from the Ombuds services, Ombuds services will be offered.

2. A designated PRSN staff or committee with appropriate clinical expertise, will review the grievance and make the decision/ offered resolution.
   - Designated PRSN staff or committee members cannot have any previous involvement, review, or decision-making in the issue(s) or case.

3. PRSN staff with the authority to resolve the grievance or require corrective action will participate in the process and offer face to face meeting with the individual to discuss the grievance. The individual may invite representatives of their choice to the meeting and have representatives of their choice involved throughout the grievance process.
   - All documentation being considered in the grievance review will be made available to the individuals and their advocate.

4. Upon conclusion of the grievance review, the PRSN will make a final determination regarding the grievance.

5. The PRSN will provide a written resolution to the individuals and their advocate as expeditiously as the mental health condition requires, typically within thirty (30) days, but not to exceed ninety (90) days of receipt of the grievance.

- The written resolution will include the reason for the decision, the results of the resolution process, the date it was completed, the process and available supports if the individual was concerned about retaliation. The notice will also include information about the process to request additional consideration via the Fair Hearing process.

  The right to request a state Fair Hearing, the process for requesting a Fair Hearing, the right to request to continue to receive benefits while the hearing is pending, how to make the request, and notice for any circumstances in which the individual may be asked to pay for the cost of those benefits if the hearing decision upholds the original decision.

  A copy of the offered resolution will be mailed to the involved network provider agency and Ombuds.

6. The PRSN will send a notice of action (NOA) to the individual about their rights to request a Fair Hearing if the PRSN fails to meet the ninety (90) day timeline to the disposition of the grievance.

Expedited PRSN Grievance Process

The PRSN will expedite the grievance process when an individual's condition requires a more immediate response to a grievance. When the individual or their advocate requests an expedited resolution of a grievance, the PRSN must respond within three (3) working days or sooner based on medical necessity of the individual.

1. Requests for expedited resolution may be initiated orally or in writing.

2. The PRSN will make a grievance review and determination, with offered resolution, as expeditiously as the individual's mental health condition requires.
   - Within three (3) working days or sooner based upon the medical necessity of the individual.
   - The PRSN will also make reasonable efforts to provide oral notice.

3. The PRSN will provide the individual or their designated advocate an opportunity to present evidence, and allegations of fact, in person as well as in writing and inform the individual of the limited time available for expedited resolution.

4. The PRSN will ensure that retaliation or punitive action is not taken against an individual who requests an expedited resolution.

5. The PRSN will provide a written resolution to the individuals and their advocate as expeditiously as the mental health condition requires and not to exceed three (3) working days of receipt of the grievance.
   - The written resolution will include the reason for the decision, the results of the resolution process, the date it was completed, the process and

available supports if the individual was concerned about retaliation. The notice will also include information about the process to request additional consideration via the Fair Hearing process.

The right to request a state Fair Hearing, the process for requesting a Fair Hearing, the right to request to continue to receive benefits while the Hearing is pending, how to make the request, and notice for any circumstances in which the individual may be asked to pay for the cost of those benefits is the hearing decision upholds the original decision.

- A copy of the offered resolution will be mailed to the involved network provider agency and Ombuds.

6. The request for an expedited review shall not cancel an individual's right to request a standard ninety (90) day grievance review.

MONITORING

1. This policy will be monitored through PRSN:
   - Annual network provider and subcontractor Administrative Reviews
   - PRSN Trainings
   - PRSN Grievance Tracking Reports. Information about unresolved individual grievances, appeals, or fair hearings that have system wide implications may be used for quality improvement.
   - Quality Management Plan activities, such as standard review of the Grievance Tracking forms and reports, analysis of targeted trends and system recommendations. Information about types of grievances, appeals, fair hearing requests and denials will be used to analyze patterns or trends and identify areas for quality improvement.
   - The Department conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.

2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for PRSN approval.

PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: APPEAL PROCESS **Policy Number:** 6.03

Reference: 42 CFR 438.214; PIHP and SMHC contract

Effective Date: 8/2004

Revision Date(s): 9/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Grievance
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Grievance Oversight and Recordkeeping
- Policy: Notice Of Action Requirements

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a standardized appeal process regarding actions for Medicaid authorization decisions. This policy is designed to outline a uniform and timely procedure for PRSN appeal process and expedited appeal requirements. The PRSN is the Pre Paid Inpatient Health Plan (PIHP).

The PRSN subcontracted Administrative Service Organization (ASO) is responsible for handling the PRSN the appeals process - standard and expedited. The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process.

The ASO may adopt more expansive definitions and procedures to ensure Medicaid enrollees receive more information and notification than required in this policy. The ASO procedure shall adhere to URAC/NCQA standards.

DEFINITIONS

Appeal means a request for review and reconsideration of an action outlined in a written Notice of Action (NOA). There is an expedited appeal process that can be activated.

An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested services, this includes individuals that do not meet Access To Care standards for authorized outpatient services and non-covered services.
- The reduction, suspension, or termination of a previously authorized service that are not mutually agreed upon.
- The denial in whole or in part, of payment for a service.
- The denial of a request for inpatient authorization.
- Disagreement of treatment plan or treatment goals between an individual and provider. This can include medication decisions.
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b), or
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network.

PROCEDURE

Medicaid enrollees or providers or representatives on behalf of the enrollee and with the enrollee's written permission may request an appeal of action to the PRSN. They may also ask for an expedited appeal. For appeals of the denial of inpatient authorization or extension request, the inpatient provider may also request an appeal or expedited appeal with written permission of the individual seeking services.

Enrollee's, providers, or other representatives may contact Ombuds services for assistance or may initiate an appeal or expedited appeal verbally or in writing with PRSN ASO.

Ombuds services are available to provide advocacy, assistance, and investigation throughout the appeals process. Ombuds services work to assist individuals or representatives with the standard and expedited appeals process listed below.

1. A Medicaid enrollee will receive a written notice of action (NOA) prepared by the PRSN subcontracted Administrative Service Office (ASO) that explains the authorization action the PRSN intends to take or has taken, the reason for the action, and the right to request an appeal or expedited appeal of these actions.
    - The notice will outline the process to appeal an action.

- PRSN network providers requesting services on behalf of the enrollee will also receive notice through the regional Profiler electronic medical record, when the PRAT is authorized.
- For denials of inpatient authorization or extension requests the inpatient provider will receive a written notice of action.
- For disagreement with a treatment plan or treatment goal.
- The PRSN office receives a copy of all notices the ASO provides for 100% review.

2. Appeals are requests by a Medicaid enrollee, provider or representative on behalf of the enrollee and with the enrollee's written permission to the PRSN for review and reconsideration of an action as outlines in the notice of an action.
    - For appeals that involve inpatient services, network community mental health agencies, agency provider staff, and inpatient providers may also request an appeal on behalf of the enrollee, with the enrollee's written permission.

3. Expedited appeals are requests by a Medicaid enrollee, provider or representative on behalf of the enrollee and with the enrollee's written permission to the PRSN for expedited review and reconsideration of an action as outlines in the notice of an action. Expedited appeals are resolved within three (3) working days of receipt.
    - For appeals that involve inpatient services, inpatient providers may also request an expedited appeal on behalf of the enrollee, with the enrollee's written permission.

4. Enrollees, or representatives on behalf of the enrollee with the enrollee's written permission, may initiate a standard or expedited appeal verbally or in writing.
    - Oral requests for standard appeals must be followed up with a signed written request by the enrollee or representative within seven (7) days.
    - Requests for expedited appeals are not expected to be followed with a written request.

5. Expedited appeals may be requested when the enrollee, provider or other representative believe that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health or ability to attain, maintain, or regain maximum functioning.

    The PRSN will follow the expedited appeal process outlined below when:

    a. An expedited appeal is requested by an enrollee or representative and the PRSN ASO determines that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental heath or ability to attain, maintain, or regain maximum function.

b. A network provider or inpatient facility indicates that the enrollee's condition requires a more immediate response and that taking the time for a standard resolution could seriously jeopardize the enrollee's quality of life like, mental heath or ability to attain, maintain, or regain maximum function.

6. Medicaid enrollee, or their designated advocate, must request an appeal within twenty (20) days of the date on the service denial (noted on the PRSN NOA notification letter).
    - Appeals must be initiated within ten (10) calendar days of the receipt of the PRSN notice for enrollees to request that their previously authorized services continue or be reinstated during the appeals process.
    - If the initial request to file an Appeal was made orally in order to establish the earliest possible filling date, a follow-up written and signed form must be received within seven (7) days.

Standard Appeal Process

1. If the enrollee is not receiving assistance from Ombuds services, Ombuds services will be offered for assistance.
    - Enrollees may have assistance from their provider or anyone of their choice, throughout the process.

2. The PRSN subcontracted ASO will document the appeal, including the date of receipt, actions taken, resolution offered, and date of notification to the enrollee.
    - The ASO will attempt to identify the concern at the time of enrollee contact. The ASO will reiterate the resources, including local Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability, to assist individuals in filing an appeal.

3. If the appeal is done verbally, the enrollee will follow up within seven (7) days of the oral request with a written signed request. Oral requests are treated as appeals and therefore establish the earliest possible filing date for appeals.

4. Written requests for appeal should include the name, address, how the PRSN can best contact the enrollee, reasons for appealing, and any evidence that enrollee or representatives wish to attach. The enrollee may send supporting records, letters from their mental health provider, a list identifying qualified witnesses, or other information that explains services should be provided. Enrollees may request information from their mental health provider.
    - The investigation may begin prior to receipt of the appeal written and signed request form.

5. The PRSN ASO will acknowledge a request for an appeal in writing and begin an investigation within one (1) working day of receipt of a written and signed appeal request (for Standard Reviews).
    - The written acknowledgement will include notice to the enrollee or representative that previously authorized services will continue or be reinstated during the appeals process at the enrollees or representative's request if:
        a. The appeal is filed in a timely manner.
        b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
        c. Services were requested by an authorized community mental health agency.
        d. The enrollee requests an continuation of services and benefits.
        e. The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.
    - The written acknowledgment will also include notice for any circumstances in which the enrollee may be asked to pay for the services received during the appeals process if the decision is not in their favor.

6. The ASO standard appeal process shall include:
    - Staff involved in the appeal process are/were not involved in previous decision-making of the case, with expertise in the mental health specialty, and whose specialty matches the attending provider's specialty as a clinical peer.
    - All outpatient and voluntary inpatient service denials will reviewed by a certified physician or psychiatrist, who is certified in the relevant clinical specialty (i.e. child and adolescent), was not involved in the previous determination, nor is a subordinate of a previous decision maker.
    - Identified review staff may request involvement from the ASO Quality Improvement Committee members. This is at the discretion of the staff member.
    - An appeal process will take into account all clinical documents, records, or other information submitted by the individual requesting the appeal, physician, provider, and/or facility relating to the case.
    - An appeal process may include contacting the attending provider for additional information and/or clarification of existing information.
    - An opportunity for the individual, or their advocate, to review their case file, including medical records and other documents and records considered during the appeal process.
    - An opportunity for the individual, or their advocate, to provide written material regarding the stated matter of concern.

- Ensure there are provisions to address retaliation against the individual requesting the Appeal.

7. The following timeframes apply for completing the standard appeal process:
   - The ASO must provide the appeal decision within forty-five (45) days from the established filing date.
   - The PRSN ASO may extend the forty-five (45) day timeframe up to fourteen (14) calendar days if:
     a. The enrollee provider acting on behalf of the individual requests the extension and there is written agreement.
     b. The PRSN shows (to the satisfaction of the State, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.
     c. Give the individual written notice of the reason for the decision to extend the timeframe and inform the individual (or their designated advocate) of the right to file a grievance, if they disagree with the decision; and
     d. Issue and carry out the determination as expeditiously as the individual's heath condition requires and no later than the date of the extension expires.

8. The decision shall be followed-up and provided in writing to the individual, facility (i.e. hospital), and network provider; with a copy sent to the PRSN office. The notice shall include:
   - The reason for the decision.
   - The results of the resolution process and the date it was completed.
   - Titles and qualification of all individuals participating in the appeal.
   - Reference the plan provision or clinical criteria on which the decision is based.
   - Notice that the specific criteria and copies of materials reviewed can be provided free of charge, upon request.
   - The support s available if there is any concern of retaliation.
   - Information about the right to request an Administrative Fair Hearing and how to do so if the enrollee believes there's been a violation of the Washington Administrative Code, does not agree to the appeal resolution, or if the PRSN fails to meet the timelines for disposition or extension of the appeal.
   - The right to request continued benefits while the hearing is pending and how to make the request; and notice that the enrollee may be responsible for the costs of those continued benefits if the hearing decisions upholds the original action.

- For denied service decisions resolved in favor of the enrollee, information about how to the enrollee may obtain services, support available to assist in obtaining service, and information that enrollees must initiate services within sixty (60) days.

9. The ASO will have formal procedures for utilization action decisions that are upheld or reversed, including written notification to the enrollee, the network provider, PRSN and other entities involved.

10. An individual, or their designated advocate, may also access an Administrative Fair Hearing if:
    - The PRSN did not provide a written response within the allowed time frames; or
    - There is a belief that there has been a violation of WA State Department of Social and Health Services rules.

11. The Administrative Fair Hearing process is accessed through the WA State Office of Administrative Hearings (1-800-583-8271).
    - An individual, or their designated advocate, must request a Fair Hearing within twenty (20) days after receiving the appeal resolution.
    - An individual may request an expedited Fair Hearing.

Expedited Appeal Process

1. Expedited appeals may be requested when the enrollee, provider or other representative believe that taking the time for a standard resolution could seriously jeopardize the enrollee's life, mental health or ability to attain, maintain, or regain maximum functioning.

2. The expedited appeal process shall meet the additional requirements listed below:

    a. Requests for expedited resolution may be initiated orally and are not required to be followed by a written signed request by the enrollee or representative.

    b. The PRSN ASO will make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's mental health condition requires, within three (3) working days or sooner based on the medical necessity of the enrollee. The PRSN ASO will also make reasonable efforts to provide oral notice.

    c. The PRSN ASO may extend the three (3) working days timeframe by up to fourteen (14) calendar days if:

- The enrollee or provider acting on behalf of the individual requests the extension and there is written agreement
- If the PRNS ASO extends the timeframes, when the enrollee does not request an extension, the PRSN will give the individual written notice of the reason for the delay.
- The PRSN ASO will provide the enrollee a reasonable opportunity to present evidence, and allegations of fact, in person (via video teleconference) as well as in writing and inform the enrollee of the limited time available for expedited resolution.
- The PRSN ASO will ensure that retaliation or punitive action is not taken against an enrollee or provider who requests an expedited resolution or supports an enrollee's appeal
- If the PRSN ASO denies a request for an expedited resolution of an appeal, it will transfer the appeal to the timeframe for a standard resolution; and make reasonable efforts to give enrollee prompt oral notice of the denial, followed up with two (2) calendar days with a written notice, and inform the enrollee of their right to file a grievance regarding the denial of expediency.

Continuation of Services during the Appeal Process

The PRSN will continue the enrollee's services/benefits if all of the following apply:

1. The enrollee or the provider files the appeal on or before the later of the following:
   - Within ten (10) calendar days of receipt of the PRSN notice, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three (3) calendar days of the intended effective date of the PRSN ASO proposed action
   - The intended effective date of the PRSN proposed action
2. The appeal involves the denial or requested services, termination, suspension, or reduction of a previously authorized course of treatment.
3. Services were requested by an authorized community mental health agency
4. The enrollee requests a continuation of services and benefits, and
5. The original period covered by the original authorization has not expired at the time of the request for continuation of benefits.

If, at the enrollee's request, the PRSN ASO continues and reinstates the enrollee's services while the appeal is pending, the services must be continued until one of the following occurs:

1. The enrollee withdraws the appeal.

2. Ten (10) days pass after the PRSN mails notice of disposition of an appeal and the resolution is not in favor of the enrollee, unless the enrollee requests a Fair Hearing (with continuation of services Fair Hearing decision is reached), or

3. The Office of Administrative Hearings issues a Fair Hearing decision adverse to the enrollee.

Enrollees who request continuation of benefits will be notified that id the final resolution of the appeal is adverse to the enrollee, the PRSN may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal was pending.

If the PRSN fails to meet the timelines concerning any appeal, they will provide the services that are the subject of the appeal. The PRSN will pay the community mental health agency to provide these services.

Effects of Reversed Resolutions of Appeals

1. If the PRSN ASO or the state Administrative Hearing Office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PRSN ASO must authorize and the community mental health agency must provide the disputed services promptly, as expeditiously as the enrollee's mental health condition requires.

2. If the PRSN ASO or the state Administrative Hearing Office reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PRSN must pay for those services.

3. If the final resolution of the appeal upholds the PRSN ASO action, the regional support network may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they ere provided solely because of the requirement for the continuation of services and in accordance with 42 CFR 431.230.

Overseeing and Monitoring of Appeal Process

The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process. The PRSN provides direct

oversight for each appeal, at the time of the appeal, and the overall process during the annual agency administrative review.

MONITORING

This policy is a federal statue and contract mandate.

1. The PRSN notice of action (NOA) policy and procedures are routinely monitored through:
    - 100% PRSN appeal of faxed copies of NOA letters mailed
    - PRSN Authorization Tracking Log provided by CommCare, upon request
    - Annual PRSN Provider and Subcontractor Administrative Review
    - PRSN Appeal Tracking Reports
    - Random checks of provider Grievance files with a cross-reference chart review
    - Quality Management Plan activities, such as review targeted issues for trends and recommendations
    - Review of previous Provider Corrective Action Plans related to Age and Cultural Competence policy, including provider profiles related to performance on targeted indicators
    - The Division conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.

2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: FAIR HEARING	**Policy Number:** 6.04
Reference: 42 CFR 438.214; PIHP and SMHC contract	
Effective Date: 8/2004	
Revision Date(s): 9/2013	
Reviewed Date: 12/2014	
Approved by: PRSN Executive Board	

CROSS REFERENCES

- Policy: Appeal Process
- Policy: Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Grievance
- Policy: Corrective Action Plan
- Policy: Grievance Oversight and Recordkeeping
- Policy: Notice Of Action Requirements

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to outline a standardized Fair Hearing process and requirements.

PROCEDURE

Right to Request a Fair Hearing

1. Individuals and their representatives have the right to request the Department of Social and Health Services (DSHS) pre-hearing and administrative hearing processes as described in Washington Administrative Code (WAC) 388-02 when:
    - An individual believes there has been a violation of the Washington Administrative Code (WAC)
    - An individual does not receive a favorable disposition of a Grievance from the PRSN or provider agency.

- A Medicaid enrollee does not receive a favorable disposition of an appeal by the PRSN subcontracted Administrative Service Organization (ASO)
- A non-Medicaid individual outpatient service episode was closed due to unavailable resources.

2. Medicaid enrollees or their representative may also request an expedited Fair Hearing when the enrollee or representative believes that taking the time for standard resolution would jeopardize the enrollee ability to maintain or regain maximum functioning.

Assistance with a Fair Hearing

1. The PRSN will provide assistance to individuals in pursuing a Fair Hearing.

2. Ombuds services are made available to investigate, advocate, and assist individuals throughout the Fair Hearing process at no cost.

3. Individuals may have a representative who acts on their behalf in requesting a Fair Hearing.
   - Individuals may also have representatives of their choice involved in the process.

4. There will be no retaliation against an individual who requests a Fair Hearing.
   - Individuals or their representatives may contact the PRSN directly if they experience of they have concerns about retaliation.

Timelines to File a Fair Hearing

1. If an individual does not receive a favorable disposition of a grievance or appeal (Medicaid only) by the PRSN or the PRSN subcontracted ASO, they may request a Fair Hearing.

2. The request for a Fair Hearing must be filed within twenty (20) days from the date of adverse ruling for appeals (Medicaid only) or twenty (20) days of notice of disposition / offered resolution of a grievance.
   - For appeals regarding termination, suspension or reduction of services the request for a Fair Hearing must be filed within ten (10) days from the date of the PRSN's notice of resolution of an appeal.

3. If an individual believes there has been a violation of the Washington Administrative Code (WAC) or the PRSN or providers have violated certain timelines, they may request a fair hearing at any time.
   - Individuals may call the Office of Administrative Hearings (OAH) at 1-800-583-8271 or Ombuds to inquire about qualifying for a state Fair Hearing prior to utilizing the PRSN grievance or appeals (Medicaid only) process.

4. If individuals are unhappy with the PRSN decision or offered resolution with a grievance, they may under certain circumstances request additional consideration of the grievance by the Department.
    - Requests must be made within five (5) days of receipt of the PRSN decision.

Where to Request A Fair Hearing

1. Individuals may request a Fair Hearing with the Office of Administrative Hearings (OAH) at 1-800-583-8271.

   OAH is part of state government that provides fair hearings to social services provided in Washington State.

   Individuals or their representatives may contact the PRSN Ombuds at (360) 692-1582 or toll free at 1- 888- 377-8174 or the PRSN at (360) 337-4604 or toll free at 1-800-525-5637 for assistance in requesting a fair hearing.

Continuation of Services during a Fair Hearing Process

1. Individuals may request that their previously authorized services or benefits continue or are reinstated during the fair hearing process, following a grievance.
    - If the fair hearing determination is not resolved wholly in the individual's favor, they may be asked to pay for those services.
2. Medicaid enrollees may, under certain circumstances request that their previously authorized services or benefits continue or are reinstated during the fair hearing process, following an appeal.

Offered Resolution

1. The Fair Hearing process must be completed within ninety (90) days of the date the appeal was initially filed, excluding any time taken by the enrollee to file for a Fair Hearing following receipt of the notice of disposition of appeal.

Reversed Resolution of Appeals

1. If the state Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while an appeal was pending, the PRSN or subcontracted ASO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's mental health condition requires.
2. If the state Fair Hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the PRSN or network provider must pay for those services.
3. If the state Fair Hearing officer upholds the PRSN appeal ruling/ action, the PRSN may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely

because of the requirement for continuation of services and in accordance with 42 CFR 431.230.

Additional Requirements for Fair Hearings

1. For Fair Hearings that involve appeals, parties to the Fair Hearing include the PRSN and the subcontracted ASO, the individual and their advocate (this may include but is not limited to family, friend, Ombuds, mental health primary care provider, mental health agency, or inpatient facility), or the estate representative of a deceased individual.
2. The PRSN, subcontracted ASO, community mental health agencies and staff, designees, network providers, and other contracted individuals and entities will cooperate with and promptly abide by all administrative hearing procedures and decisions.
3. The PRSN will require this cooperation in policy, contracts, and monitor requirement.

MONITORING

This policy is a federal statue and contract mandate.

1. The state fair hearing policy and procedures are routinely monitored through:
    - Tracking PRSN appeals notices and review of notices mailed
    - Closely monitoring appeal requests that CommCare handles on PRSN behalf
    - Participation (as a party) in all Fair Hearings
    - PRSN Grievance & Appeals Reports
    - Spot checks of provider Grievance files with a cross-reference chart review
    - Quality Management Plan activities, such as review targeted issues for trends and recommendations
    - The Division conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.
2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: NOTICE OF ACTION REQUIREMENTS **Policy Number:** 6.05

Reference: 42 CFR 438.210, 438.404, 438.10;
WAC 388-865-0255, PIHP and SMHC contract

Effective Date: 8/2004

Revision Date(s): 1/2014

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Appeal Process
- Policy: Grievance, Appeal, and Fair Hearing General Requirements
- Policy: Grievance
- Policy: Corrective Action Plan
- Policy: Fair Hearing
- Policy: Grievance Oversight and Recordkeeping

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a process for Medicaid enrollees to be notified of denials, intended actions, adverse actions and how to pursue appeals in a manner that gives timely, clear, and easily understood information to persons seeking and receiving publically funded mental health services.

This policy is intended to outline the definitions, PRSN procedures and responsibilities as they relate to the federal Notice of Action (NOA) regulations. The PRSN subcontracted Administrative Service Organization (ASO) is responsible for sending the PRSN NOA letter and conducting the standard and expedited NOA Appeal process.

The PRSN is responsible for overseeing, is accountable for, and monitors the functions and determinations resulting from the ASO appeal process.

The ASO may adopt more expansive definitions and procedures to ensure Medicaid recipients/enrollees receive more information and notification than required in this policy. The ASO procedure shall adhere to URAC standards.

DEFINITIONS

Appeal means a request for review and reconsideration of an action outlined in a written Notice of Action (NOA). There is an expedited appeal process that can be activated.

An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested services, this includes individuals that do not meet Access To Care standards for authorized outpatient services and non-covered services.
- The reduction, suspension, or termination of a previously authorized service that are not mutually agreed upon.
- The denial in whole or in part, of payment for a service.
- The denial of a request for inpatient authorization.
- Disagreement of treatment plan or treatment goals between an individual and provider. This can include medication decisions.
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b), or
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network.

Denial is a decision to not offer an intake assessment or a decision by the PRSN (or their formal designee) to:

- Not authorize requested mental health services to enrollee's . This includes a request for service for individuals that do not meet Access To Care standards, requested covered and non-covered services, as well a disagreement with a Treatment Plan or treatment goal.
- Not authorize a service within the timeframes (i.e. 14 days admission authorization), without a network provider extension request.
- Not authorize a request for inpatient services

Reduction is a decision by the PRSN (or their formal designee) to:

- Decrease an enrollee's previously authorized covered Medicaid mental health services described in their Level of Care Guidelines.
- Decrease or change an authorized service documented in the ISP/Treatment Plan that is mutually agreed upon is not a reduction.

Suspension is a decision by the PRSN (or their formal designee) to:

- Temporarily stop an enrollee's previously authorized covered Medicaid mental health services described in their Level of Care Guidelines.
- Temporarily stop or change an authorized service documented in the ISP/Treatment Plan that is mutually agreed upon is not a suspension.

Termination is a decision by the PRSN (or their formal designee) to:

- Stop an enrollee's previously authorized covered Medicaid mental health services described in their Level of Care Guidelines.
- Stop or change an authorized service in the ISP/Treatment Plan that is mutually agreed upon is not a termination.

Continuation of Services means to continue to provide services with no changes in type of frequency, where applicable, throughout the duration of the appeal process.

PROCEDURE

The PRSN community mental health network provider agencies are responsible for assessing, establishing, and documenting medical necessity based on statewide Access to Care criteria.

The PRSN subcontracted Administrative Service Organization (ASO) is responsible for authorizing care for using the PRSN Levels of Care standards and clinical assessment documentation provided by the network agency.

Notice of Action Information Requirements

1. All notices and forms discussed in this policy are available in English, Spanish, and all other prevalent non-English language spoken in PRSN regional services area as defined by the DSHS. The template letter will be made available and translated into an individual's primary language, when requested, to meet language requirements, per CFR 438.10 (c&d).

2. PRSN and the network providers shall explain the authorization and appeal process to all persons requesting and receiving services (or their custodial caretaker) at the time of assessment and when requesting continued services in a manner that is understandable to the individual.
    - This may include the use of qualified sign-language interpreters for those persons with hearing impairments, oral explanations for individuals with visual impairments, persons with limited ability to read English or are developmentally disabled, and explanations in languages other than English.

- Copies of all authorizations and actions are placed in a client's clinical record (or scanned into the electronic medical record), thereby documenting the determination. Forms, that are mailed, will be mailed in a manner that documents date sent.

The PRSN receives copies of all notices, resulting from an action determination, mailed to a client and/or facility (on behalf of a client) from the ASO.

The PRSN mails approval letter for all outpatient authorizations directly to the client.

These correspondence records are maintained in the PRSN office

3. The notice must provide all required information. Explanations provided by the PRSN and/or network provider regarding the reasons for the decision must be complete, written in commonly understood language and specific to the person receiving the services. Generic statements are not adequate.

4. All notices required by this policy are sent to :
   - The individual seeking mental health services (or their legal caretaker).
   - A legal guardian or parent who is the legal custodian of a person under the age of consent.
   - Notices on behalf of inpatient services are copied to the requesting network provider agency, inpatient facility, and PRSN office.

5. The PRSN NOA letter is:
   a. In writing.
   b. In the enrollee's primary language and to be easily understood.
   c. Explains the action the PRSN or the ASO has taken or intends to take.
   d. Explains the reason of the action.
   e. Provides definitions for reduction, termination, suspension, and denial.
   f. References to the service provision, clinical criteria, guideline, protocol, and/or statue.
   g. Provides information that the specific criteria referenced is available, upon request and free of charge.
   h. Explains the enrollee's, or the community mental health agency's right to act as an advocate, in filing an Appeal of Action.
   i. Explains the procedures for exercising the enrollee's rights.
   j. Explains the circumstances under which the expedited resolution is available.
   k. Explains the enrollee's right to have services continue pending resolution of an appeal, how to request that services be continued, and the circumstances under which the enrollee may be required to pay the costs of these services; and be mailed as expeditiously as the enrollee's mental heath condition requires.

Notification Timeframes

1. For utilization management decisions regarding a denial or limit of a request for standard authorization of services:
   - The PRSN ASO will mail notice as expeditiously as the individual's health condition requires, not exceeding fourteen (14) days following receipt of the request for services, with a possible extension of up to fourteen (14) additional calendar days if:
     a. The individual requesting the services requests an extension, or
     b. The network provider or ASO justifies a need for an extension and how the extension is in the person's best interest. PRSN will provide a written notice of the reason to extend the timeframe and will inform the person of their grievance and appeal rights if they do not agree with the decision.

        For extensions, the determination will be provided as expeditiously as the individual's health condition requires and no later than the date the extension expires.
     c. Service authorization decisions not reached in accordance with the timeframes established per contract constitutes a denial and an Action, which is subject to Appeal.

   - The PRSN ASO will mail the written notice by priority mail.
   - The PRSN ASO may determine that following the standard timeframes could seriously jeopardize the life, health, or ability to attain, maintain, or regain maximum functioning of the person making the request. A PRSN ASO must make an authorization decision within three (3) business days after the receipt for request of service.

     The PRSN ASO may extend the three (3) day time period by up to fourteen (14) calendar days if the request is made by the person requesting the services, or if the authorization decision and extension is in the person's interest.

2. For utilization management decisions regarding denials, termination, suspension, or reduction of previously authorized Medicaid covered services:
   - The PRSN ASO will mail notice at least ten (10) days prior to the effective date of action.

3. For utilization management decisions regarding cases of probable fraud:
   - The notice may shorten the period of advance notice to five (5) days before the date of the action if there are facts indicating that action should be taken because of probable fraud by the client and the facts have been verified, if possible, through secondary sources.

4. For utilization management decisions regarding denial of payment, the notice shall be provided at the time of any action effecting the payment.

5. The ASO will send the PRSN NOA to enrollees and effected parties with a copy mailed to the PRSN office for 100% review.

6. Administrative notices may be provided on the date of the change/intended action in the following circumstances:
   - Confirmation of the individual's death.
   - The individual has been admitted to a public institution precluding the eligibility for the service.
   - The individual has moved out of the catchment/service area.

Requesting an Appeal

An enrollee, or their designated advocate, must request a PRSN NOA Appeal within twenty (20) days of the date on the PRSN NOA letter. Appeals must be initiated within ten (10) calendar days of the receipt of the PRSN notice to enrollees to request that their previously authorized services continue or be reinstated during the appeals process.

- If the initial request to file an Appeal was made orally in order to establish the earliest possible filling date, a PRSN Appeal request form will be sent to the enrollee. The form must be returned and signed as a follow-up to oral filings within seven (7) days.

MONITORING

1. This policy is a federal and contract mandate. This policy will be monitored through use of PRSN:
   - Annual PRSN Provider and Subcontractor Administrative Review
   - PRSN Trainings
   - PRSN Grievance Tracking Reports
   - 100% PRSN review of all service denial and NOA letters
   - The Division conducts the Mental Health Statistical Improvement Project (MHSIP) every year, one year for adults and the alternating the next year for children/ youth. The MHSIP measures general consumer satisfaction with the existing service delivery system, appropriateness and quality of services, participation in treatment goals, access to services, and perceived outcomes of services they received. The PRSN requests over sampling of the region to gather specific catchment area data and analyze for trends.

2. If a provider/contractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES

7-2014

Date:

To: **Name**
Address
Town WA zip code

From: CommCare, on behalf of the Peninsula Regional Support Network (PRSN)
1627 Main Street, Suite 1100
Kansas City, MO 64108

This is to let you know about an action we are planning to take concerning your Medicaid-funded mental health services that you requested or are currently receiving.

Your mental health center services at _____ **will be:**

- o **DENIED**
  EFFECTIVE DATE _____
- o **REDUCED TO** __ _____ **FROM** __ __
- o **EFFECTIVE DATE** _____
- o **SUSPENDED**
  EFFECTIVE DATE _____
- □ **TERMINATED**
  EFFECTIVE DATE _____

The reason for this decision is:

- o You are no longer a resident in the service area.
- o You do not meet medical necessity criteria because (specify principal reason) _____.
- o Other:

However, you are entitled to a second opinion.

CONTACT PERSON CONCERNING THIS NOTICE: CommCare at (877) 777-1388

Upon request, CommCare will provide in writing the clinical rationale, a more detailed clinical description of the non-certification reason. To request the clinical rationale please call CommCare or send your written request using the above telephone number or address.

IF YOU DON'T AGREE WITH THIS DECISION, you have the right to appeal. If you choose this right, you have twenty[1] (20) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact: CommCare at (877) 777-1388 or send your appeal to the address above.

If YOU NEED HELP WITH FILING AN APPEAL you may contact the PRSN Ombuds Service at 1-800- 377-8174. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may also have other persons of your choice assist you during the appeal process. If you want someone else to assist you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

Before you file an appeal, please see, "Important Information About Your Appeal Rights" on the next page.

[1] If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Denial: The decision to not offer a requested service is considered a denial. This includes requested services that are non-covered and services that are not deemed medically necessary.

Suspension: The decision by a PRSN, or other formal designee, to temporarily stop your previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. If this decision is mutually agreed upon with you, it is not considered a suspension.

Reduction: The decision by a PRSN to decrease an your previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. If this decision is mutually agreed upon with you, it is not considered a reduction.

Termination: The decision by a PRSN, or their formal designee, to stop an your previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. If this decision is mutually agreed upon you, it is not considered a termination.

There Are Two Kinds of Appeals You Can File

Standard (45 days) You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited (Fast, 3 working days) You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we receive your appeal request. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
  If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the CommCare address listed on the front of this letter. You may verbally request an appeal but it must be followed in writing within 7 days.

For an Expedited Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact CommCare or the PRSN office by telephone or fax. CommCare: (877) 777-1388
PRSN office: (800) 525-5637

Can I Continue to Receive Services? If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from the Notice of Action letter mailed date.
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services;
- The current period covered by the authorization has not expired, and the Notice of Action letter was mailed to you timely
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?
You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to the CommCare or present this information in person at your local agency.

What happens after I file an appeal?
Staff from CommCare who were not involved in the decision review your appeal and provides a written decision within 45 days unless an extension has been requested.

What Happens Next?
After CommCare makes a decision about your appeal and you do not agree with the Appeal final decision, you may ask for a Fair Hearing through the State Office of Administrative Hearings (1-800-583-8271).

You must request a Fair Hearing within 20 days after you receive the Appeal final decision. Your services may continue during this process.

You may also access a Fair Hearing if:

- CommCare, on behalf of the PRSN, did not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Additional Contact Information
CommCare: (877) 777-1388
PRSN office: (800) 525-5637

PRSN Ombuds Service: (888) 377-8174

Washington State Department of Social and Health Services, Office of Administrative Hearings:
P. O. Box 42488
Olympia, WA 98504-2488
(800) 583-8271

NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH INTAKE ASSESSMENT 9-2013

To: (Name and Address) **Date:**

From: CommCare, on behalf of the Peninsula Regional Support Network (PRSN)
1627 Main Street, Suite 1100
Kansas City, MO 64108

This is to let you know about an action we are planning to take concerning your Medicaid-funded mental health services that you requested or are currently receiving.

Your mental health intake assessment conducted at _____ on _____(date) determined that the information you presented did not meet the entrance criteria developed by the State of Washington Department of Social and Health Services for outpatient services.

During the intake assessment conducted by a mental health professional, it was determined you, or the individual seeking services: (check if applicable)

- ___ **Does not have a covered mental health diagnosis.**
- ___ **Does not meet the global functioning assessment score for services.**
- ___ **The impairment(s) and corresponding need(s) are not the result of a mental disorder or diagnosis.**
- ___ **Is not expected to benefit from intervention services available through the public mental health system.**
- ___ **The intervention services available cannot reasonably improve, stabilize or prevent deterioration of functioning resulting from the presence of the emotional or mental disorder or diagnosis.**
- ___ **The unmet needs are more appropriately met by another formal or informal system or support. We refer you to: _____.**
- ___ **Does not have Title XIX Medicaid coverage, and there is not sufficient state funding to authorize outpatient services.**
- ___ **Other: _____**

You do have a right to a second opinion and may request another intake assessment within 30 days from the date of receiving this letter. You also have a right to Appeal the intake assessment determination.
The decision is based on law 42 CFR 438.

IF YOU DECIDE TO REQUEST A SECOND OPINION, please contact the mental health agency and request a second opinion intake assessment.

IF YOU DECIDE TO REQUEST AN APPEAL, you have twenty (20) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact: CommCare, toll free at (877) 777-1388 or send your appeal to the address listed above.

If you make your request verbally, you will be asked to put it in writing within seven (7) days. If your request is not put in writing, we will consider the request incomplete and not take further action.

IF YOU NEED HELP FILING AN APPEAL you may contact the PRSN Ombuds Services toll free at 1-888-377-8174 or (360) 692-1582. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may also include other persons of your choice to assist you during the appeal process. If you want someone to assist you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

What happens after I file an appeal? CommCare reviews your appeal and provides a written decision within 45 days.

Frequently Asked Questions

There Are Two Kinds of Appeals You Can File

Standard (45 days) You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited (Fast, 3 working days) You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we receive your appeal request. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the CommCare address listed on the front of this letter. You may verbally request an appeal but it must be followed in writing within 7 days.

For an Expedited Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact CommCare or the PRSN office by telephone or fax.

CommCare: (877) 777-1388
PRSN office: (800) 525-5637

Can I Continue to Receive Services? If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from the Notice of Action letter mailed date.
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services;
- The current period covered by the authorization has not expired, and the Notice of Action letter was mailed to you timely
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?

You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to the CommCare or present this information in person at your local agency.

What happens after I file an appeal?

Staff from CommCare who were not involved in the decision review your appeal and provides a written decision within 45 days unless an extension has been requested.

What Happens Next?

After CommCare makes a decision about your appeal and you do not agree with the Appeal final decision, you may ask for a Fair Hearing through the State Office of Administrative Hearings (1-800-583-8271).

You must request a Fair Hearing within 20 days after you receive the Appeal final decision. Your services may continue during this process.

You may also access a Fair Hearing if:

- CommCare, on behalf of the PRSN, did not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Additional Contact Information

CommCare: (877) 777-1388
PRSN office: (800) 525-5637

PRSN Ombuds Service: (888) 377-8174

Washington State Department of Social and Health Services, Office of Administrative Hearings:
P. O. Box 42488
Olympia, WA 98504-2488
(800) 583-8271

NOTICE OF ACTION ABOUT YOUR TREATMENT PLAN

9-2013

To: **Date:** _____

From: CommCare, on behalf of the Peninsula Regional Support Network (PRSN)
1627 Main Street, Suite 1100
Kansas City, MO 64108

Network mental health agencies are required to have a mutually agreed upon Treatment Plan for every Medicaid individual justifying the medically necessary services they provide.

Because you do not agree with your Treatment Plan, this is a notice to let you know that you have a right to Appeal the Plan and how to request an Appeal.

Your mental health center services at _____ will continue to be authorized while you request and proceed through the Appeal process. You have a right to have services continue pending resolution of the Appeal.

CommCare conducts a review of all appeal requests made by individuals served by the Peninsula Regional Support Network (PRSN). They will provide you a resolution in writing after making a determination within 45 days of receiving your Appeal request.

- **The written resolution will include your rights regarding a Fair Hearing and how to file a Fair Hearing, and**
- **If the Appeal decision is no wholly in your favor, you may be asked to pay for the cost of continued services if the Fair Hearing decision upholds the original decision regarding the Treatment Plan.**

To file an Appeal request, please contact: CommCare, toll free at (877) 777-1388

IF YOU DON'T AGREE WITH THIS DECISION, you have the right to appeal. If you choose this right, you have twenty[1] (20) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing.

If you make your request verbally, you will be asked to put it in writing within seven (7) days. If your request is not put in writing, we will consider the request incomplete and not take further action. You may refile your appeal within twenty (20) days from the original receipt of the notice.

IF YOU NEED HELP FILING AN APPEAL you may contact the PRSN Ombuds Services toll free at 1-888-377-8174 or (360) 692-1582. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may also include other persons of your choice to assist you during the appeal process. If you want someone to assist you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

What happens after I file an appeal? CommCare reviews your appeal and provides a written decision within 45 days. For additional information, please see the "Important Information about Your Appeal Rights" listed on the back of the letter.

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[1] If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Denial: The decision to not offer a requested service is considered a denial. This includes requested services that are non-covered and services that are not deemed medically necessary.

Suspension: The decision by a PRSN, or other formal designee, to temporarily stop your previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. If this decision is mutually agreed upon with you, it is not considered a suspension.

Reduction: The decision by a PRSN to decrease an your previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. If this decision is mutually agreed upon with you, it is not considered a reduction.

Termination: The decision by a PRSN, or their formal designee, to stop an your previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. If this decision is mutually agreed upon with you, it is not considered a termination.

There Are Two Kinds of Appeals You Can File

Standard (45 days) You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited (Fast, 3 working days) You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we receive your appeal request. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the CommCare address listed on the front of this letter. You may verbally request an appeal but it must be followed in writing within 7 days.

For an Expedited Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact CommCare or the PRSN office by telephone or fax.

CommCare: (877) 777-1388
PRSN office: (800) 525-5637

Can I Continue to Receive Services? If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from the Notice of Action letter mailed date.
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services;
- The current period covered by the authorization has not expired, and the Notice of Action letter was mailed to you timely
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?
You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to the CommCare or present this information in person at your local agency.

What happens after I file an appeal?
Staff from CommCare who were not involved in the decision review your appeal and provides a written decision within 45 days unless an extension has been requested.

What Happens Next?
After CommCare makes a decision about your appeal and you do not agree with the Appeal final decision, you may ask for a Fair Hearing through the State Office of Administrative Hearings (1-800-583-8271).

You must request a Fair Hearing within 20 days after you receive the Appeal final decision. Your services may continue during this process.

You may also access a Fair Hearing if:

- CommCare, on behalf of the PRSN, did not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Additional Contact Information
CommCare: (877) 777-1388
PRSN office: (800) 525-5637

PRSN Ombuds Service: (888) 377-8174

Washington State Department of Social and Health Services, Office of Administrative Hearings:
P. O. Box 42488
Olympia, WA 98504-2488
(800) 583-8271

PENINSULA RSN

GRIEVANCES AND APPEALS POLICIES AND PROCEDURES

Policy Name: GRIEVANCE REPORTING INSTRUCTIONS **Policy Number:** 6.08

Reference: PIHP and SMHC Contract

Effective Date: 7/2005

Revision Date(s): 9/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: Appeal Forms
- Form: Grievance Forms for Medicaid and Non- Medicaid

PURPOSE

The Center for Medicare and Medicaid Services (CMS, formerly known as HCFA) requires the Department to report the frequency of grievances, appeals and Fair Hearings separately for children and adults for each half of the federal fiscal year. The report is also made available to individual RSNs for their review, analysis and for incorporation of the findings into local quality management functions.

The Grievance and Appeal forms and instructions are developed and distributed by the Department.

DEFINITIONS

A Case means documentation of a grievance, appeal or Fair Hearing request and subsequent efforts to resolve the expression of dissatisfaction. A case **is counted only once** even though it may involve more than one type of issue or more than one provider agency. It may begin as a 1st Level Grievance and continue through to a 2nd Level PRSN Grievance and Fair Hearing levels but will still be counted as one case.

A Grievance is any expression of dissatisfaction by an individual with RSN related services. Filing grievances should be a common standard practice at the provider

agency and PRSN level; and not described to individuals in any way that discourages the process. It is expected that the network provider agencies and PRSN will encourage and support an individual using the formalized grievance system.

- 1st level grievances are filed by an individual at the provider level.
- 2nd level grievances are filed by the individual at the PRSN level, either as an initial grievance or filed as a result of dissatisfaction with the 1st level grievance.

Issues of dissatisfaction that are filed by ancillary systems or unauthorized family member are resolved outside the formal grievance system. Issues of dissatisfaction related to Medicaid *actions* (authorization decisions) are resolved through the RSN appeal process.

Appeal means a request for review and reconsideration of an action outlined in a written Notice of Action (NOA). There is an expedited appeal process that can be activated.

An Action in the context of Medicaid services includes:

- The denial or limited authorization of a requested services, this includes individuals that do not meet Access To Care standards for authorized outpatient services and non-covered services.
- The reduction, suspension, or termination of a previously authorized service that are not mutually agreed upon.
- The denial in whole or in part, of payment for a service.
- The denial of a request for inpatient authorization.
- Disagreement of treatment plan or treatment goals between an individual and provider. This can include medication decisions.
- The failure of the PRSN to act within the timeframes provided in section 42 CFR 438(b), or
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b) (2) (ii), to obtain services outside the network.

DSHS Administrative Fair Hearing means a hearing conducted through the auspices of the state Office of Administrative Hearings in accordance with Washington Administrative Code (WAC) 388-02. An issue of dissatisfaction must complete the PRSN Grievance/and Grievance Appeal process prior to requesting a DSHS Administrative Fair Hearings. The term Fair Hearing is synonymous with Administrative Hearing.

PROCEDURE

1. Due Dates

The PRSN is required to submit all the Grievance and Appeal reporting forms, along with an analysis narrative to the Department for each time period listed below:

Time Period	Due Date
October1 through March 31	May 15
April 1 through September 30	November 15

2. Required Fields

RSN Name, Contact Name, Contact Person's Phone Number and Reporting Period

Cases

The total unduplicated number of cases, for adults and for children, is required. Please see the definition of "Case" and the example for more information on how to count cases.

Services provided to adults and children and counted separately.

Outstanding

At the end of the report period, some cases will not be resolved or closed. Enter the number of unresolved cases in the Outstanding column in the corresponding row that reflects the type of the case.

Resolutions

A case should be reported in the Resolutions section when it is closed or when it progresses to a higher level, i.e. Grievance or Fair Hearing.

Outstanding From Last Period

This column should be used to report cases that were tallied in the Outstanding column of the Occurrences portion of the report in the previous report period.
In some cases, the number of "Outstanding from Last Period" will equal the number of Outstanding in the previous report. In some cases, it will not. It does not have to.

This feature of the report is an indicator of the number of cases that are resolved within six (6) months or less.

3. Collecting Numbers

- Grievances: The PRSN will compile the requested and processed Grievances at the agency and PRSN level for PIHP and state funded services numbers to complete the grievance columns.
- Appeals: The PRSN will request the number of PIHP requested and processed Appeals for PIHP individuals from CommCare. These numbers are compiled to complete the Appeals form.

4. Grievance and Appeal Report Analysis

- The PRSN will analyze the forms, over time, and compile a narrative report of the noted trends and outliers.
- The report will include possible explanations for outliers and trends.
- The report will include QUIC activities to the reporting time period and planed activities, if applicable.

5. Department Requested Revisions

a. The Department reviews each submitted Grievance and Appeal report. Upon request, the PRSN will provide any additional follow-up information or revised reports with an explanation of the reporting error, as well as a corrective plan to address/ prevent on-going reporting errors.

6. QUIC Oversight

The Quality Improvement Committee (QUIC) provides the oversight and monitoring of the PRSN compliant, grievances, and appeals tracking and resolutions.

The QUIC is provided quarterly Ombuds trends, grievances and appeal reports at the quarterly meeting.

The QUIC also is provided and discusses the Grievance and Appeals reports, the meeting after the report and forms are submitted to the Department as a contract deliverable.

The PRSN or the QUIC may require PRSN further action and/or network provider specific corrective action.

PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: ADVANCE DIRECTIVES **Policy Number:** 2.02

Reference: DSHS Contract, RCW 71.32, and 42 CFR 438.6

Effective Date: 7/2005

Revision Date(s): 12/2011

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Crisis Prevention Plan Standards

PURPOSE

The Peninsula Regional Support Network (PRSN) network providers shall provide information to all adult consumers regarding their right to create an advance directive. Advance Directives shall include and demonstrate an individual's voice in developing the plan(s).

PROCEDURE

1. Information must be provided to enrollees at the time of their enrollment in the mental health system:
   a. At the time of enrollment all adult persons must receive information regarding:
      - The person's rights regarding advance directives under Washington State law
      - A description of the applicable state law
      - Information regarding the implementation of these rights
2. The network community mental health providers must periodically make persons aware of the option to enter into an advance directive.

3. The network community mental health providers must ask if a person has an existing medical or mental health advance directive.
5. The network community mental health providers must display educational material regarding advance directives, such as the PRSN Advance Directives brochure, including rights under the law of the state to any service receipt that requests it.

6. The network community mental health providers must:
    - Assist adult persons who are interested in developing and executing an advance directive
    - Document, in the adult person's clinical record, whether or not the adult person was provided the information and whether an advance directive was executed
    - Not discriminate against an adult person because of his or her decision to execute or not to execute an advance directive
    - Provide a copy of a person's executed advanced directive, or documentation of refusal, to the acute care primary care provider (PCP) for inclusion in the person's medical record.
    - Provide advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials (in accordance with state law) to an individual is incapacitated at the time of initial enrollment and is unable to receive information or unable to articulate whether or not he or she has executed an advance directive.

      Ensure follow-up procedures to verify the advance directive information is given to the individual at the appropriate time (i.e. once he or she is no longer incapacitated or unable to receive such information).
    - Inform individuals concerned about non-compliance with the advance directive may be filed with the state survey and certification agency.
    - Develop an internal agency mechanism for easy identification of clinical records with Advance Directives, such as for crisis response workers.

MONITORING

This policy is mandated by statue and contract.

1. This policy will be monitored through use of PRSN:
    - Annual PRSN Provider and Subcontractor Administrative Review
    - Annual Provider Standard and Crisis Chart Review
    - Biennial Provider Quality Review Team On-site Review.

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: ENROLLEE RIGHTS **Policy Number:** 2.11

Reference: 42 CFR 438.10 and 438.100, WAC 388-877-0600

Effective Date: 8/2003

Revision Date(s): 7/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: PRSN Client Rights Statement (optional)
- Policy: Corrective Action Plan

PURPOSE

Medicaid enrollees shall be notified of their rights under federal and state law and regulation.

The Peninsula Regional Support Network (PRSN) shall ensure consumer rights are uniformly provided throughout the provider network. The PRSN provides a standardized outpatient rights form to be used by the core network providers for Medicaid and non-Medicaid individuals.

DEFINITIONS

Enrollee means a Medicaid recipient who is currently enrolled in a pre-paid inpatient health plan (PIHP).

PROCEDURE

The PRSN promotes customer satisfaction and requires through the network providers that all consumers be knowledgeable of and protected by certain rights.

The PRSN provides a standardized set of outpatient rights that includes federal, state, and contract required client rights. The PRSN client right's statement is required to be used for all PRSN funded outpatient services.

Each network agency is responsible for providing Least Restrictive Alternative Order (LRAO) rights and inpatient (voluntary and involuntary), if applicable.

1. An individual shall receive notification of their rights in accordance with CFR 438.10 and WACs that includes the following mechanisms:
    - The Washington Department of Social and Health Services distributes an enrollee booklet annually to all Medicaid recipients that includes client rights
    - The PRSN handbook includes the general information about enrollee rights. The PRSN mails the handbook directly to enrollees at the time of service authorization (admission or continuing services).
    - PRSN contracted providers shall provide a copy of the PRSN standard outpatient client rights to each individual in their primary language at the time of admission for services.

      This requirement is included in their contract with the PRSN.
    - PRSN contracted providers shall provide/ post the PRSN standard outpatient enrollee rights form in various public access areas through the community mental health agency (CMHA) main campus building and outstations.

      This requirement is included in their contract with the PRSN.
2. An individual shall be treated with respect and with due consideration of individual dignity and privacy.

3. An individual shall receive information on available treatment options and alternatives, presented in a manner appropriate to the individual's condition and ability to understand.
    - An individualized plan of care and services is developed.

4. An individual shall participate in decisions regarding their health, including their right to refuse treatment. This includes Involuntary Treatment Acts, chapters 71.05 and 71.34 RCW.

5. An individual shall be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience ore retaliation, as specified in federal regulations on the use of restraints and seclusion. Services shall be free of any sexual exploitation or harassment.

6. An individual can request and receive a copy of their medical records, and request they be amended or corrected (according to 45 CFR 164.524 and 164.526).

7. An individual has the right to be furnished medically necessary health care services.
    - Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation.
    - Receive an explanation of all medications prescribed, including expected effect and possible side effects.

8. An individual has the right to exercise their rights and to be free of adverse effects from the PRSN or provider network.

9. The PRSN Ombuds service shall be familiar with client rights and be available to explain rights to Medicaid enrollees. An individual shall have the right to lodge a grievance with the Ombuds person, PRSN or provider if they feel their rights have been violated. If a complaint is lodged, their will be no retaliation.

10. The PRSN and network providers must comply with other federal and state laws, including:
    - Title IV of the Civil Rights Act of 1964
    - The Age Discrimination Act of 1975
    - The Rehabilitation Act of 1973
    - Title II and III of the Americans with Disabilities Act
    - and other laws regarding privacy and confidentiality

MONITORING

This policy is a mandated by statue.

1. This policy will be monitored through use of PRSN:
    - Annual PRSN Provider and Subcontractor Administrative Review
    - Annual Provider Chart Reviews
    - Grievance Tracking Reports
    - Biennial Provider Quality Review Team Review
    - Quality Management Plan activities, such as review targeted issues for trends and recommendations

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

PRSN Client Rights Statement
Outpatient Services
Revised 8/2013, Implemented 9/1/2013

Client and prospective clients, or legally responsible others, are entitled to the following rights when seeking publically funded mental health services.

1. The right to receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.
2. The right to participate in decisions regarding your healthcare including the right to refuse any proposed treatment consistent with Chapter 71.05 RCW and 71.34 RCW and CFR 438.100(iv).
3. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
4. The right to receive appropriate quality care and treatment, employing the least restrictive alternatives available.
5. The right to receive emergent, urgent, or crisis services.
    - For Medicaid recipients, you have a right to receive post-stabilization services following hospitalization.
6. The right to be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
7. The right to receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age, or disability.
8. The right to practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice.
9. The right to be free of any sexual harassment.
10. The right to be free of exploitation, including physical and financial exploitation.
11. The right to request a second opinion from a qualified health care professional at no cost.
12. The right to receive the services of a certified language or sign language interpreter and written materials in alternate formats to accommodate disability consistent with Title VI of the Civil Rights Act.
13. The right to be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.
14. The right to plan for your care and be involved in the creation of your individual treatment plan which addresses your unique needs.
15. The right to receive direct access to mental health professionals for beneficiaries with special health care needs.
16. The right to have all clinical and personal information treated in accordance with state and federal confidentiality regulations.
17. The right to review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections. You may request a copy of your records and will be told the cost for copying.

18. The right to receive an explanation of all medications prescribed, including expected effect and possible side effects.
19. The right to expect that any research you agree to participate in will be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in WAC 388-04.
20. The right to choose an outpatient primary care provider at the time of enrollment, to change your primary care provider within the first 90-days and once during any 12-month period for any reason, and at any time for good cause (WAC 388-865-0345).
21. The right to make an advance directive, stating your choice and preference regarding your physical and mental health treatment if you are unable to make an informed decision.
22. For Medicaid recipients, the right to receive all services which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from:
    a. A provider within the regional support network about what services are medically necessary; or
    b. For consumers not enrolled in a prepaid health plan, a provider under contract with the Department of Social and Health Services (DSHS). .
23. If you are currently receiving Medicaid benefits, you will not be billed for Medicaid covered services.
24. The right to receive a copy of agency complaint and grievance procedures upon request and to lodge a complaint or grievance with the agency or Peninsula Regional Support Network (PRSN), if applicable, if you believe your rights have been violated.
25. The right to file a Fair Hearing complaint with the department when you feel the agency has violated a WAC requirement regulating health care agencies. The right to file an administrative hearing with DSHS without first accessing the PRSN grievance process.
26. The right to lodge an agency or PRSN grievance with the Ombuds' office, PRSN, or provider, if you believe your rights have been violated. If you lodge an agency or PRSN grievance, you shall be free of any act of retaliation. The Ombuds' office may, at your request, assist you in filing. The Ombuds' phone number is 1-888-377-8174.
27. The right to have a mental health professional or network agency advise or advocate for you with respect to CFR438.102(i-iv) without PRSN restriction.
28. For Medicaid recipients, the right to a Notice of Action appeal for any denial, termination, suspension, reduction of services, or disagreement with your plan of care and continue to receive services until your appeal is determined.

    To file an Appeal you may:

    a. Contact the Ombuds' office, or have an advocate, for assistance in filing an Appeal and throughout the Appeal process
    b. File a PRSN Appeal with the PRSN by calling 1-800-525-5637
29. To receive information about the structure and operation of the PRSN. The right to request a directory of agency providers available in the PRSN that provide alternative languages other than English.
30. To freely exercise any and all rights and exercising these rights will not adversely affect treatment by the provider, the PRSN or DSHS.

PRSN Outpatient Client Rights Signature Page

Revised 8/2013, **Implemented 9/1/2013**

Attached to the document is the agency Grievance Procedure and PRSN Privacy Rights.

We appreciate your signed acknowledgement below that you have been provided this information.

I have read these client rights and give my consent to treatment.

Client Signature: _____ Date: _____

PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: GENERAL INFORMATION REQUIREMENTS **Policy Number:** 2.07

Reference: WAC 388-865-0330; 388-877A-100; -0120; -0600
42 CFR 438.100(b) (2&3)

Effective Date: 9/2005

Revision Date(s): 12/2012

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to plan and implement actions which ensure individuals eligible for mental health services are notified of the existence, availability, and scope of services within the PRSN. The PRSN will regularly and consistently provide information that assists the enrollee's progress toward recovery and resiliency.

PROCEDURE

1. The PRSN shall provide to persons served by the RSN information on the following topics, through the Department of Social and Health Services (DSHS) Medicaid Benefits Booklet and PRSN produced materials:
    - Access to Care
    - Covered Title XIX and State Funded Services
    - Consumer/Member Service Contact Information
    - Provider Network
    - Grievance, Appeals and Fair Hearings Rights
    - Ombuds Program

- Consumer Rights
- Signs of Mental Illness
- Availability of written materials in alternative formats and how to access those formats

2. In addition to English, the PRSN shall provide the information described above in the following prevalent languages, upon request:
   - Cambodian
   - Chinese
   - Korean
   - Laotian
   - Russian
   - Spanish
   - Vietnamese

3. The PRSN shall:
   - Provide written materials in easily understood language and format, including alternative formats
   - Post client rights in the languages set forth above
   - Provide access to written interpretation of all consumer materials
   - Provide access to these materials prior to conducting an intake evaluation
   - Maintain a publically accessible internet website

4. The PRSN will provide annual training to providers, subcontractors and local NAMI organizations on the efforts to provide general information to the region.

   This will include, but is not limited to the availability of mental health services, how to access and request information and how to exercise their rights.

MONITORING

This policy is mandated by statue.

1. This policy will be monitored through use of PRSN:
   - Annual PRSN Provider and Subcontractor Administrative Review
   - Biennial QRT On-site Reviews
   - Exhibit N Reports and Grievance Tracking
   - Monthly Ombuds reports to the Quality Improvement Committee (QUIC).

2. If a provider performs below expected standards as identified through the reviews and reports listed above, a corrective action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: INTERPRETER SERVICES AND ASSISTANCE	**Policy Number:** 2.14
Reference: DSHS Contract, WAC 388-865-0220 -0222;	
Effective Date: 4/2005	
Revision Date(s): 12/2011	
Reviewed Date: 12/2014	
Approved by: PRSN Executive Board	

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Comprehensive information Plan for Delivery and Services
- Policy: General Information Requirements

PURPOSE

It is the policy of the Peninsula Regional Support Network (PRSN) to establish a process that clients are provided interpreter services and assistance in completing forms and taking procedural steps to obtain services.

PROCEDURE

1. Network providers are required to post the Department of Social and Health Services (DSHS) required seven languages informing individuals of their outpatient rights. See PRSN Comprehensive information Plan for Delivery and Services and General Information Requirements.
2. Network providers are to post the "Point to your Language" signs in common areas, such as agency lobby.
3. Agency staff, including receptionists, shall be trained on how to respond and provide assistance to an individual using the "point to your language sign".
4. Standard policy and procedure for requests of reasonable assistance for any services within the PRSN includes, but is not limited to:

- Interpreter services, when needed
- Toll free numbers for TTY/TTD interpreter capability

5. When interpreter services are requested, the network provider will identify an interpreter using:
   - DSHS Language Line Services by calling 1-866-874-3972. The network providers are to use the PRSN designated client ID.
   - DSHS website at http://www.dshs.wa.gov/ltc/about.shtml with local resources listed.
     a. The network provider will contract directly with the interpreter for the interpreter services
     b. When an interpreter is not available, or non-existent in a local area, the PRSN can assist in locating and arranging for interpreter services
6. Interpreter services shall be made available for the following:
   - Treatment planning
   - Direct services, to include individuals and family members

MONITORING

This policy is a mandate by contract and statue.

1. This policy is monitored through use of PRSN:
   - Annual PRSN Provider and Subcontractor Administrative Review
   - Annual Provider Chart Review
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy

Policy Name: Quality Management Plan **Policy Number:** 10.01

Reference: State Mental Health Contract; Prepaid Inpatient Health Plan; PRSN provider state contract; PRSN provider PIHP contract; WAC 388-865-0280; 42 CFR 438-240

Effective Date: 1/2000

Revision Date(s): 12/2012

Reviewed Date: 1/2014

Approved by: PRSN Executive Board

OVERVIEW

The Peninsula Regional Support Network (PRSN) Quality Management Plan is a working document created to ensure the on-going practice of evaluating, monitoring and improving the quality of mental health services delivered within the three counties served by the PRSN. The Quality Management Plan is approved by the PRSN Quality Improvement Committee (QUIC) and the Executive Board and facilitated by PRSN staff.

ELEMENTS OF THE QUALITY MANAGEMENT SYSTEM

Executive Board

The Executive Board is the main leadership and decision-making body of the PRSN. The Executive Board is comprised of three county commissioners from each constituent county: Kitsap, Jefferson and Clallam. The Executive Board meets quarterly and receives updates from the Quality Improvement Committee (QUIC) and recommendations from the PRSN Advisory Board, Quality Review Team (QRT) and staff, as appropriate. Based on recommendations, the Executive Board may require contract modifications.

PRSN Staff

The PRSN staff manages and facilitates the daily operations of the network. The PRSN staff consists of one full-time administrator who supervises a full-time Quality Assurance Manager/HIPAA Officer, Clinical Review Manager, Resource Development Manager/Compliance Officer, Children's Services Coordinator, Fiscal Officer, and an administrative support position. These staff members provide technical support to providers and are on-site as needed or at least quarterly. They also provide support to the QRT, QUIC, Advisory and Executive Boards. Information Systems services are contracted through Kitsap Mental Health Services. The PRSN contracts with a not-for-profit administrative services organization, CommCare, for service authorization, and utilization

management. If any position is vacant, other staff will assume the responsibilities of that position in facilitating the Quality Management Plan.

Advisory Board
The purpose of the PRSN Advisory Board is to provide community and consumer input to the Executive Board and staff. The Advisory Board consists of five members from each of the three constituent counties. At least 51% of the board consists of mental health consumers or their family members. The Advisory Board meets monthly to review reports from the PRSN staff, QUIC and QRT. The Advisory Board then makes recommendations to the PSRN staff and Executive Board. Optimally, at least two members of the QUIC serve on the Advisory Board.

Ombuds
The PRSN Ombuds advocates for clients and assists providers to ensure dignified and quality services. The Ombuds operates independently from the PRSN and providers. The Ombuds reports to the QUIC, QRT and PRSN Administrator trends concerning client perceptions, family satisfaction and ancillary provider issues.

Quality Improvement Committee (QUIC)
The QUIC provides oversight of the quality improvement process and activities for the PRSN. PRSN strives to achieve a QUIC membership comprised of at least 6 members who represent the perspective of those who have received or are receiving services in a publicly funded mental health system. These members may include representatives from the QRT, the Advisory Board, peer counselors or the Ombuds staff. Membership may also include an individual or family member of an individual who is not affiliated with one of these groups, who has received or is receiving publicly funded mental health services. Finally, there are representatives from each of the four providers, and a PRSN staff to facilitate. At least one member is an individual whose perspective and experiences support the interests of children and families. The QUIC meets at least quarterly, to review system-level trends and to make recommendations to the PRSN regarding quality assurance issues and opportunities for improvement within the network. The QUIC also provides direct oversight of the PRSN Compliance Plan and Utilization Management Committee.

Quality Review Team (QRT)
The purpose of the QRT is to monitor and evaluate the delivery of mental health services within the PRSN. The QRT consists of five to ten members who are appointed by the PRSN Advisory Board and are representative of the demographics of the region. It includes consumers, family members and advocates. The QRT gathers information by conducting biennial, on-site reviews of each provider and reports their findings along with recommendations to the providers, the PRSN, the QUIC, Advisory Board, and to the State of Washington Department. Our goal is for at least one QRT member serves on the QUIC.

Utilization Management Committee (UMC) and Clinical Directors Meeting (joined)
The Utilization Management Committee and Clinical Directors meeting have been combined, and are co-chaired by the PRSN Resource Development Manager and Adult Services Manager. It systematically monitors and evaluates service authorization, clinical appropriateness and utilization trends to ensure enrollees are receiving timely and appropriate services to meet their needs. The members are responsible for the PRSN Utilization Management Plan and Levels of Care documents. In addition, the members

evaluate the network to ensure there is adequate services and appropriate use of resources throughout the system. This process is continuous and focuses on quality and cost effectiveness. The Committee meets monthly and consists of the PRSN Resource Development Manager, PRSN Adult Services Manager, provider representatives, and the CommCare Clinical Care Manager. The PRSN Administrator and the CommCare Psychiatric Medical Director may provide consultation to the UMC. The meeting reports trends and region-wide issues to the PRSN Administrator; and to the QUIC, as applicable.

Mental Health Service Providers

There are five community mental health providers located in Kitsap, Jefferson and Clallam Counties. They are; Peninsula Behavioral Health (formerly known as Peninsula Community Mental Health Center), West End Outreach Services, Jefferson Mental Health Services, Kitsap Mental Health Services and RMH Services. Providers have an organizational structure and quality assurance systems unique to their agency. The provider agencies have their own Quality Management (QM) Plan that incorporates the PRSN QM Plan.

PURPOSE

The activities of this plan seek to assure compliance and continuous improvement within the system regarding:

- Cultural competency
- Age appropriate services
- Commitment to recovery, rehabilitation, and reintegration philosophies
- Clinical practices based on valid and reliable evidence
- Coordination and continuity of care
- Appropriate utilization of services
- Maintenance of capacity
- Accessibility
- Enrollee participation
- Stakeholder participation
- Continuous system improvement

MONITORING TOOLS AND ACTIVITIES

The quality management functions of the PRSN monitor performance in four main areas: quality of services, satisfaction, administrative practices, and compliance. The PRSN analyzes information gathered through quality assurance tools and activities to develop improvement strategies to enhance quality in any one or more of the identified categories.

The following chart describes the quality assurance activities and tools used to monitor performance in each of four categories:

	Quality of Services	Satisfaction	Administrative Practices	Compliance
Surveys	Quality Review Team (QRT) Site Visits and Reports WIMIRT Consumer Satisfaction Data			
Reports	Quality Indicators Tracking Ombuds Monthly Activity and quarterly Grievance Reports Resource Utilization Trends	Ombuds Monthly Activity and quarterly Grievance Reports	Provider Performance Summary Report Revenue and Expenditure Report	CommCare Monthly Authorization Reports (standard authorizations, denials/appeals, and re-admission hospitalizations) Peninsula Regional Assessment Tool (PRAT) Report
Reviews	Standard Chart Reviews Practice Guideline Reviews Crisis Chart Reviews High Utilizer Chart Reviews Under-Utilization Chart Reviews Residential Services Reviews Evaluation and Treatment Center Reviews Ad Hoc Reviews Sentinel Events Reviews/Tracking Annual Review	QRT Site Visits Grievance and Appeal Tracking Annual Review	Provider and Subcontractor Administrative Review Sub delegation Contractor Reviews Annual Review	Chart Reviews (as listed in Quality of Services column) Data Integrity Reviews Provider and Subcontractor Administrative Reviews PRSN Compliance Plan and Committee Charter Sub delegation Contractor Reviews Annual Review

	Quality of Services	Satisfaction	Administrative Practices	Compliance
Meetings	QUIC Meeting QRT Meeting UMC & Clinical Directors Meeting DMHP Meeting Clinical Staffing/Care Management Meetings Network agency Financial Directors Meetings Compliance Committee Tribal Meetings	QUIC Meeting QRT Meeting UMC & Clinical Directors Meeting DMHP Meeting Network agency Financial Directors Meetings Compliance Committee Tribal Meetings	QUIC Meeting UMC & Clinical Directors Meeting DMHP Meeting Network agency Financial Directors Meetings Compliance Committee Tribal Meetings	QUIC Meeting UMC & Clinical Directors Meeting DMHP Meeting Network agency Financial Directors Meetings Compliance Committee Tribal Meetings

COLLECTING AND ANALYZING INFORMATION

Information regarding the quality and appropriateness of care consumers receive through the network services is gathered from the array of sources and activities, as listed above. Trends and issues identified through the collection and analysis of information are reported to the providers, the PRSN Administrator, the QUIC and/or the Advisory Board. Plans for collecting and analyzing information are as follows:

Chart Reviews and Other Targeted Reviews

Description: The standard and crisis chart reviews are a key quality assurance activity performed by the PRSN staff to monitor and analyze the quality and intensity of services as well as the fit between services needed and those actually provided (See 9.05a Standard Chart Review Tool and 9.05b Crisis Chart Review Tool). Additional chart review tools may be developed when trends are identified through the results of quality assurance activities that warrant and ad hoc review.

Specifically, these chart review tools and processes:

- evaluate the continuity of services from the consumer's request for services through discharge,
- assess the degree to which services progress the consumer toward recovery and resiliency,
- incorporate items from the Department Licensing tool for inter-rater reliability,
- include items that evaluate provider compliance with the PRSN contract, policies and pertinent WAC regulations;
- include items that monitor crisis services, timeliness of response, incorporation of individual and family voice and provision of services in least restrictive environments;

- include items that monitor appropriateness of authorization practices for outpatient admission and continuing care,
- include items that monitor over and underutilization of services,
- client needs such as age related, cultural and linguistic related, coordination of care for special populations, housing and linkages with other systems, and
- cultural and linguistic competence;
- monitor that consumer rights are clearly stated;
- monitor and explore targeted issues as identified by quality indicators tracking or other indicators,
- evaluate treatment plans for timeliness, participation of enrollee and natural supports, applicable consultation with specialists, and other WAC requirements, and
- monitor coordination of care with other systems, and with consumers' PCP

Data Collection and Analysis Plan: The PRSN staff conducts analyses of consumer care covering a representative sample of at least five hundred consumers, primarily through chart reviews, annually. In general, the numbers of reviews are divided proportionally among providers based on the number of individuals served. The representative sample may include the following types of targeted reviews:

- Reauthorization-focused
- Admission-focused
- Crisis Services
- High Utilization
- Underutilization Reviews
- Intake reviews of Individuals not authorized for care
- Supported Employment Services
- Residential Services
- Evaluation and Treatment Center Services
- Practice Guideline Adherence

Additional analyses of care may be conducted as indicated by results of monitoring activities. Data collected from chart reviews are compiled and analyzed by PRSN staff as reviews are completed. Reports are prepared and compared with previous reviews to identify trends and evidence of improvement. Review results are reported to the providers, and the PRSN Administrator. System-wide trends are reported to QUIC.

Practice Guideline Reviews:

Description: The PRSN adopts practice guidelines based on valid and reliable research-based clinical evidence demonstrating their utility in driving positive clinical outcomes, reflecting promising practices, or reflecting a consensus of national mental health professionals. The PRSN practice guidelines are adopted from the American Psychiatric Association (APA), and include one for Schizophrenia and one for Bipolar Disorder. (See 11.15 Practice Guidelines). Each practice guideline has a corresponding monitoring tool. (See 11.15c Bipolar Practice Guideline Chart Review Tool and 11.15d Schizophrenia Bipolar Practice Guideline Chart Review Tool)

Data Collection and Analysis Plan: At least once per year a sample of charts of active clients with a diagnosis of schizophrenia, and bipolar disorder will be reviewed for adherence to the appropriate guideline. Results will be provided to providers.

Over and Under-Utilization Monitoring Project

Description: PRSN expects each consumer to receive the right type and amount of service. PRSN has a variety of mechanisms in place to detect both overutilization and underutilization of services. These include: Reports and data describing utilization trends, Quality Indicator Tracking, Administrative Reviews, and Admission and Reauthorization focused Chart Reviews, and other quality assurance monitoring results. When potential over and under utilization trends are detected, PRSN responds by developing specific projects to investigate, define, and correct system problems. These projects may be developed in consultation with stakeholders through the Advisory Board, QUIC, UMC, or Network Provider Clinical Directors.

Data Collection and Analysis Plan: PRSN has multiple methods to detect over and under utilization such as:

- Examination of authorized level of service and service provision match and clinical appropriateness through chart reviews
- Reports that examine trends of inpatient utilization including length of stay at the evaluation and treatment center versus community hospitals
- Data describing authorization and service trends and patterns
- Quality indicators measuring inpatient utilization per capita for youth, follow-up services after inpatient services, timely access to services, and inpatient readmission rates
- Data describing utilization patterns for specific modalities of service
- Complaint and grievance patterns

Current projects include:

Overutilization: The PRSN generates a report identifying consumers who have had more than one hospitalization within 30 days. PRSN will evaluate data and services. Services will be evaluated using the crisis chart review tool which has a section with review items for high utilization only (See 11.09 and 11.09b). System trends and improvement plans are be reported to QUIC as identified.

Underutilization: PRSN identifies a sample of intakes of clients for whom a determination that "access to care standards" were not met. These intakes are reviewed for thoroughness, quality, and whether adequate information was documented to justify the determination. This project is completed at least once per year. Regional trends are reported to the QUIC. The QUIC may delegate any regional trends to the appropriate regional committee for problem solving, with results reported back to QUIC.

Over/Underutilization: PRSN's Children's Care Manager provides monitoring and leadership regarding the authorization of continued care for youth inpatient stays as well as requests for admissions to Children's Long Term Inpatient Programs (CLIP) to ensure that services for youth are provided in the least restrictive setting. This monitoring is provided at least weekly.

Sentinel Events

Description: The PRSN assures all contract required sentinel events occurring within the network are reported to The Department and reviewed in a standardized way as per policy. (See PRSN Policy 2.01 Sentinel Events)

Data Collection and Analysis Plan: Sentinel events are recorded through provider reports, and tracked on a spreadsheet. The spreadsheet is used to identify trends, track

investigations, and analyze concerns. The PRSN records, reports, and reviews sentinel events occurring within the region (see PRSN Policy 2.01 Sentinel Events). The PRSN works with the provider(s) to collect and forward information to The Department regarding efforts to prevent or lessen the possibility of similar incidents in the future, as appropriate. Chart reviews and targeted reviews of provider critical incident files may be performed as necessary. The UMC/Clinical Directors review the annual trends noted on the PRSN Incident spreadsheet annually and may review specific incidents, as well as recommend further, region-wide system improvements Compliance with this policy is also monitored through the Administrative Review process.

Data Integrity Reviews

Description: The PRSN monitors the accuracy of data reported by comparing it to documentation in the clinical notes.

Data Collection and Analysis Plan: a random sample equal to or greater than 411 encounters sent to The Department for services during the contract year are compared with service documentation in the clinical file. The encounters are selected from 100 client charts. Verification for each randomly selected encounter record includes the following minimum data elements: date of service, name of service provider, service location, procedure code (i.e., CPT and HCPCS) and modifiers (if applicable), service unit/duration, and provider type, and whether the service code agrees with treatment described. Analysis and reporting includes findings of error rate for each data element and aggregate the results for the following categories:

- Match – Match reflects cases where there are exact matches of all the minimum data elements for each randomly selected sample between the Subcontractor's encounters and those in the clinical records

- No Match – No match reflects cases where the Subcontractor's encounters do not match the clinical records. There are three (3) error types for this category:
  1. Erroneous – Encounters that occurred and are presented by an electronic record, but contain incorrect data or missing any of the minimum data elements.
  2. Missing (i.e., Not in Encounter Record) – Clinical record contains evidence of a service but is not represented by an electronic record.
  3. Unsubstantiated (i.e., Not in Medical Record) – Encounters submitted by the Subcontractor but either cannot be verified in the clinical record or is duplicated.

PRSN will aggregate the findings by the error types. Reports are provided to each provider at least annually. Review results are also reported to the PRSN Administrator, and PRSN Compliance Officer. System-level trends are reported to the QUIC.

Peninsula Regional Assessment Tool (PRAT) Report

Description: PRSN monitors the timely authorization process outlined in the provider contract and PRSN Level of Care requirements. The PRAT is a tool used by all of the providers in the region to describe an assessment and request for outpatient authorization of services. The PRAT Report analyzes the number of PRATs submitted to CommCare more than two weeks past the service request date. It also identifies the number of

admission, continuing care, and inactivation outpatient authorization requests sent to CommCare from each provider, which allows the UMC to target trends by type of PRAT request. Finally, it monitors the time taken from request for authorization to authorization determination by CommCare.

Data Collection and Analysis Plan: The data for this report is gathered monthly and sent to PRSN by CommCare and analyzed by the Resource Development Manager. The report is reviewed at the monthly UMC meetings.

Resource Utilization Trends Reports

Description: The Resource Utilization Trends report is generated by CommCare and describes statistics and patterns regarding authorization and utilization of services. The description includes inpatient, outpatient, residential services; and call volume.

Data Collection and Analysis Plan: Per the PRSN Utilization Management Plan, utilization management data is collected from the monthly authorization tracking reports. (See 7.06 Utilization Management Plan) The Resource Development Manager and the UMC analyzes the reports for trends and opportunities for improvement relating to service authorization and utilization.

Inpatient Discharge Report

Description: PRSN uses this report to monitor each authorized inpatient discharge on a standardized report. The report identifies information by network provider, as well as hospital. The report is used to identify inpatient length of stay and discharge patterns, by provider and/or hospital.

Data Collection and Analysis Plan: The data for this report is gathered monthly and sent to PRSN by CommCare and analyzed by the Resource Development Manager. The report is reviewed at the monthly UMC meetings.

Inpatient Retro-Denial Report

Description: PRSN uses this report to monitors each requested inpatient retro-active authorization and authorization denial. The report provides number of retro-authorizations requested and by what hospital, as well as the scenario with each request. The report is used to report any inpatient denials. The report identifies information by network provider, as well as hospital, so that trends of concern are easily recognized and addressed immediately.

Data Collection and Analysis Plan: The data for this report is gathered monthly and sent to PRSN by CommCare and analyzed by the Resource Development Manager. The report is reviewed at the monthly UMC meetings.

Inpatient 30-Day Re-admission Report

Description: PRSN developed this report as a request from the Utilization Management Committee earlier this year. This report lists the number of monthly inpatient re-admissions within 30-days from a previous inpatient discharge. The report is used to identify re-admission trends and quality of care/ coordination concerns from an inpatient discharge. This report may continue to add elements and develop more sophisticated identification and analysis.

Data Collection and Analysis Plan: The data for this report is gathered monthly and sent to PRSN by CommCare and analyzed by the Resource Development Manager. The report is reviewed at the monthly UMC meetings.

Quality Indicators Tracking

Description: The PRSN has established Quality Indicators as part of the PRSN Quality Management Work Plan that measure performance, effective service delivery and network efficiency. (See 10.04 Quality Indicators) Contract and CFR requirements; and data collected from chart reviews, administrative reviews, satisfaction surveys, Provider Performance Summary reports and other data maintained in the PRSN Information System drive the Quality Indicators. All Performance Indicators required by contracts with The Department are included as quality indicators. Additionally there are at least two ongoing regional performance indicators identified with input from the PRSN Advisory Board, as required by contract, and reflect one of the following areas:

- Access and Availability
- Care Coordination and Continuity
- Effectiveness of Care
- Quality of Care
- Hope, Recovery, and Resiliency
- Empowerment and Shared Decision Making
- Self Direction
- Cultural Competency
- Health and Safety Measures
- Consumer Health Status and Functioning
- Community Integration and Peer Support
- Quality of Life and Outcomes
- Promising and Evidence-Based Practices
- Provider effectiveness and satisfaction
- Integrated Programs and Systems Integration

A report describing these indicators and their progress is delivered to The Department annually by January 15th and includes the following information:

- Name of the indicator
- Study population and time period
- Numerator/Denominator
- Data source/sample size if applicable
- Exclusion Criteria, if any
- Justification for choosing each measure
- Improvement Target
- Annual calculation and progress
- Explanation or Corrective Action Plan if target is not reached

Regional Performance Indicators are identified on the Quality Indicators Document and reviewed quarterly at QUIC and annually by the PRSN Advisory Board
Stakeholder input to development of all Quality Indicators is achieved through consultation with the Advisory Board and the QUIC.

Data Collection and Analysis Plan: The Quality Assurance Manager collects data, calculates measures, and develops an analysis for each quality indicator. Findings are reported to providers as appropriate. All indicators are reported to QUIC at least annually. The QUIC evaluates the impact and effectiveness of the indicators and modifies them as appropriate. Baseline and targets are established for each indicator. Data collected and analyzed for each indicator assists the PRSN to identify necessary improvements and

implement change to enhance the overall quality of mental health services within the region. All results of contract indicators required by the state will be made available to the public.

Regional Surveys

Description: Consumer satisfaction and outcome data for the PRSN is collected from several sources, including:

1. **QRT Interviews:** The QRT gathers information about consumer satisfaction and quality of service (See 9.06 Quality Review Team).
2. **The Mental Health Statistics Improvement Program (MHSIP) Survey:** The MHSIP survey is conducted once per year by the Washington Institute for Mental Illness Training and Research (WIMIRT). Clients who have received mental health services are randomly selected to participate in the survey. Various outcomes, including National Outcome Measures (NOMS) and satisfaction ratings are measured.

Data Collection and Analysis Plan:

1. The QRT conducts biennial, on-site interviews of each provider and ancillary providers. Findings and generated improvements are presented to the PRSN Advisory Board, and may be reviewed by the QUIC if recommended by the Advisory Board.
2. Once the annual results are published, PRSN staff develops a summary for review and discussion by the QUIC of the MHSIP survey results annually. Agency specific MHSIP results may also be provided as deemed necessary by the QUIC.

The QUIC uses information from these sources to determine the degree to which mental health services are driven by individual/family voice and participation and meeting the needs of consumers, and to shape improvement activities in the region.

Grievance and Appeal Tracking

Description: The PRSN has a system in place for individuals to pursue, grievances and appeals; and access DSHS administrative Fair Hearings. (See Chapter 6 - Complaint, Grievances and Appeals Policies) The PRSN generates the Grievance deliverable report, as required by The Department, which tracks PRSN grievances, appeals and DSHS Fair Hearings for adult and children's services. PRSN also tracks agency trends on a separate quarterly report. The Ombuds provides monthly reports that track the Ombuds outreach activities, as well as a customized Concerns report that captures issues outside the definition of a Grievance.

Data Collection and Analysis Plan: All PRSN contracted provider agencies report Grievances to the PRSN on a quarterly basis. The Ombuds forward monthly reports on concerns and grievances in the network to the QUIC and PRSN Administrator. The Ombuds also report trends and issues they have identified to the QUIC at quarterly intervals. The PRSN collects grievance data directly submitted and resolved within the PRSN office. All service denial and appeal data is collected from CommCare. PRSN compiles The Department biannual Grievance report from the above referenced sources. The QUIC reviews the PRSN Grievance report to assess trends and inform quality assurance activities.

Utilization Management /Clinical Director's Meetings and Clinical Staffing Meetings

Description: PRSN staff members provide technical assistance, collaboration, and leadership regarding effective clinical practices, adherence to statutes, and utilization and resource management through regional meetings with Clinical Director's, DMHPs, and through clinical staffing meetings as a means towards system improvement. This meeting is also used to share statewide system changes, such as Medicaid expansion and Children's System Re-design.

Data Collection and Analysis Plan: If concerning trends are identified they are presented to the appropriate group for development of a plan to address the issue. The QUIC maintains oversight through feedback loops including information about plans and outcomes of the issues addressed at regional clinical meetings.

Provider Performance Summary Report:

Description: The PRSN generates a monthly Provider Performance Summary Report to describe numbers of services and hours for each state plan modality, utilization rates for inpatient services and crisis services, penetration rates and other performance statistics. These are calculated by agency and for the region as a whole.

Data Collection and Analysis Plan: The Provider Performance Summary is reviewed by the PRSN Administrator, the Executive Board, the QUIC, and by the UMC when issues of concern regarding utilization, such as over or under utilization, or capacity are revealed. Concerns and identified trends will be reported to the providers and the Advisory Board.

Administrative and Sub-Delegation Reviews:

Description: The PRSN has a standardized process for network provider and sub-delegation administrative reviews (See 9.03 Provider-Subcontractor Administrative Review Policy). The purpose of the reviews is to monitor provider and subcontractor administrative and compliance practices.

Data Collection and Analysis plan: Provider and Sub-delegation Administrative Reviews are conducted annually by PRSN Staff. (See 9.03a PRSN Administrative Review Tool, 3.10a Subcontractor Delegation and Assessment Tool, ASO; and 3.10b Subcontractor Delegation and Assessment Tool, IS) These reports provide feedback and recommendations using measurement standards consistent with industry standards. Results of Administrative Reviews are summarized for the Advisory Board, system-wide-trends are reported to QUIC, and reports are published on the PRSN website. . (See PRSN Policy 9.03 Provider-Subcontractor Administrative Review)

Compliance Plan

Description: The PRSN Compliance Plan establishes a culture within the network that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law; and federal and state funded health care program requirements. (See 5.17a Compliance Plan, 4 and 5.17b Compliance Plan Checklist,) The PRSN Compliance Committee oversees the annual review and revision of the Compliance Plan. The Committee finalized an accompanying Compliance Charter that outlines their roles and responsibilities. PRSN staff members, governing board members, QUIC members, QRT

members, network contractors and subcontractors that encompass the operations of the PRSN are expected to act in accordance with the PRSN Compliance Plan.
Data Collection and Analysis Plan: The Compliance Plan includes mechanisms to immediately investigate and report allegations of Medicaid fraud and abuse to the statewide reporting entity, Medicaid Fraud Control Unit. The PRSN compliance officer reviews compliance plans and evidence of applicable trainings through the administrative reviews occurring annually for each provider and subcontractor. The PRSN facilitates regional implementation(s) of new state and federal compliance requirements, such as monthly excluded parties reviews. The review includes consideration as to whether the compliance issue is a system-wide trend, warranting regional investigation. Recommendations are made as appropriate. The PRSN compliance Officer provides an annual overview of each fiscal year compliance issues to the QUIC.

Revenue and Expenditure Reports:
Description: Financial and cost information for each provider is gathered and analyzed by the Administrator through biannual revenue and expenditure reports, annual provider audits and the annual cost report.
Data Collection and Analysis Plan: The financial and cost information is compared against statewide averages and historical trends. Each network provider is monitored annually by a PRSN team which examines justification for all line item expenditures, and ties expenditures reported in the agencies Revenue and Expenditure report back to agency primary records. Fiscal reports are shared with staff from the Division of Behavioral Health and Rehabilitation, and if unsubstantiated billings are identified network providers are required to return funds. Regional meetings occur quarterly with agency financial directors to provide technical assistance and clarification of the Revenue and Expenditure report.

Annual Review
Description: PRSN ensures that reviews of the network providers within the region are conducted at least annually to include:

- Timely access that meets the Access Standards set forth by The Department.
- Consistent referrals with primary medical care.
- Efforts to pursue and report third party revenue.
- Quality Improvement activities including Performance Improvement Projects.
- The Implementation of Practice Guidelines co-occurring assessment for quadrant placement of individuals.
- Efforts to create the expectation and support the delivery of mental health services that are driven by the incorporate the voice of the Enrollee and those they identify as family.
- The degree to which mental health services delivered are age, culturally and linguistically competent.
- Monitoring activities performed are in place to make sure that attempts are made to provide mental health services in the least restrictive environment.
- A review of services that are being provided that promote recovery and resiliency.
- Local efforts to provide services that are integrated and coordinated with other formal/informal service delivery systems.

Collected data such as monitoring activities and results, external quality review findings, agency audits, consumer Grievances and services verification are incorporated into feedback and quality assurance activities.

Data Collection and Analysis Plan: Elements described above are collected through chart reviews, administrative reviews, and other review processes described in this plan.

PERFORMANCE IMPROVEMENT PROJECTS

In addition to monitoring performance in quality of services, satisfaction, administrative practices, and compliance, PRSN also conducts two performance improvement projects (PIPs) at all times. (See PRSN Policy 10.02 Performance Improvement Projects) These projects are aimed at assessing and improving processes, and thereby outcomes, of care. All PIPs conducted by PRSN will target improvement in relevant are of both clinical care and non-clinical services, and will seek to improve services beyond minimal compliance with contract terms and statutes.

INCORPORATING FEEDBACK

PRSN will incorporate feedback from monitoring and analysis activities described in this plan. This feedback is incorporated into the PRSN quality management and improvement processes from a variety of stakeholders including:

- **Consumers and family members**
  - Feedback is continually gathered from their participation on the QRT, QUIC and Advisory Board.
  - Input is gathered through the consumer and family focus groups which are facilitated biennially for each provider by the QRT.
  - Satisfaction data for the PRSN is collected from the Washington Institute for Mental Illness Training and Research (WIMIRT)
  - Inter-Tribal meetings are held biannually with the PRSN, network providers and local Tribal Social Services/ Wellness program directors to ensure culturally competent services and system coordination.

- **Network Providers**
  - Input is gathered through their participation on the QUIC and UMC.
  - Input may also be gathered through Clinical Director's meetings, DMHP meetings, the UMC, the QUIC, or other meetings.
- **Other Stakeholders**
  - Feedback is gathered and incorporated from the monitoring activities of the External Quality Review Organization (EQRO).
  - Feedback is incorporated from the monitoring activities of The Department.
  - Results of monitoring activities described in this plan are summarized and reviewed by the QUIC, and reported to the Advisory Board and Executive Board as appropriate. Results of each monitoring activity will documented and communicated to each network provider, as applicable.
- Each Network Provider is expected to develop a plan to address areas needing improvement.
- The QUIC identifies opportunities for improvement and makes recommendations based on findings. Recommendations may include development of procedural

changes or clinical practices. Changes may be facilitated by the Network Providers, the Advisory Board, the UMC, the Clinical Directors, or other processes developed within the PRSN.

- The Clinical Directors Meeting, facilitated by the PRSN Clinical Review Manager, use monitoring results and recommendations made by the QUIC to inform their choices when developing clinical standards, changing clinical practices, and/or implementing evidenced based practices.
- The Clinical Review Manager uses results from the monitoring process to inform the PRSN sponsored trainings for Network Providers.
- Utilization Management Committee, facilitated by the PRSN Resource Development Manager, uses the information from the quality assurance activities described in this plan, to identify barriers to improvement and maximize utilization management mechanisms.
- The Financial Directors meeting, facilitated by the PRSN Resource Development Manager, and attended by the PRSN Administrator and Fiscal Officer providers a format to share information, standardize financial reports, and provide training information.
- The Compliance Committee meets quarterly according to the Compliance Charter to review new regulations, share protocols, and discuss local scenarios.
- The Designated Mental Health Professional (DMHP) meeting, facilitated by the PRSN Clinical Review Manager, addresses issues directly related to the crisis and inpatient coordination aspects of the delivery system.
- The PRSN administrator may meet with executive directors from each provider agency as necessary to review and discuss administrative issues, agency compliance and cost efficiency. The QUIC may coordinate with any of these processes to develop system interventions, as necessary.
- Based on information from the PRSN administrator and QUIC, the Advisory Board evaluates whether implementation of system changes are effective and may make recommendations for system-wide improvements to enhance the quality of services within the network. The advisory board may report their recommendations the PRSN administrator and/or the Executive Board for further action.
- The Executive Board may require contract modifications. When the Executive Board requires contract modifications, the PRSN Administrator is responsible for implementation. The PRSN Administrator and staff evaluate if contract terms resulting from Executive Board action are effectively and consistently implemented throughout the network.

ACCOUNTABILITY

The PRSN Executive Board, consisting of the three elected county commissioners from each constituent county, demonstrates ultimate local accountability. The PRSN must respond to direct citizen feedback about the quality and sufficiency of services available and local cost shifts (to jails or public health), and develop strategies to meet the unique cultural and geographic characteristics within the catchment area.

Providers and subcontractors are held accountable for compliance with statutes, regulations, contract requirements and agreements through the PRSN Compliance Plan, annual Provider and Subcontractor Administrative Reviews and Sub-delegation Reviews, and other quality assurance activities described in this plan. All feedback and plans

resulting from it will be documented. Information generated from each of these functions is disseminated to the Administrator and summarized for the QUIC and the Advisory Board.

Administrative Reviews: If deficiencies or areas for improvement are noted in the results of an administrative review, corrective action plans are required within 30 days of receiving the written report from the PRSN. (See PRSN Policy 9.09 Corrective Action Plan)

Chart Reviews: Both summaries and Individual feedback for each chart review are provided providers following the completion of the reviews. Feedback includes recommendations regarding any issues of concern as well as notations highlighting exceptional examples of quality care or documentation. It is expected that providers will address any issues of concern. Feedback will include systemic patterns of strengths and areas requiring improvement. Generally, tabulated items scoring below 90% on a particular review summary require a system level action plan for improvement, and may result in a formal request for a corrective action plan. Regional trends are identified annually.

Timely Authorization Process: When the percentage of overdue PRATs reaches 15 or more in any given month for a provider, a corrective action plan is required. Each corrective action plan is presented and reviewed at the monthly UMC meeting.

QRT: When the QRT conducts in-depth appraisals of each provider's services, they make recommendations to the ancillary providers. Providers are expected to respond within 30 to 60 days in writing to the QRT recommendations, stating which recommendations they will implement including timeframes, and provide explanations for the recommendations they do not plan on implementing. Providers are also expected to provide a report within 12 months describing their current status regarding implementation of recommendations.

Quality Indicators: When any quality indicator measure falls below the established benchmark as described in this policy (see 10.04 Quality Indicators) for more than one quarter without at least a 10% improvement, a system level action plan for improvement may be required, and a formal request for a corrective action plan may be requested. All benchmarks for quality indicators that are also core performance measures required by The Department will be consistent with those provided in the contract between PRSN and The Department. When a quality indicator that is required by The Department does not meet the threshold described in this policy, a performance improvement project may be required by The Department.

- **Data Integrity:** Data discrepancies in the clinical record that are identified through the data integrity review process must be corrected as possible. A formal request for a corrective action plan will be requested on any analysis that reveals an error rate outside of acceptable standards. Acceptable standards are as follows:

Type	Acceptable Standards	
	Year 1	Year 2
Match	$\geq$ 95%	$\geq$ 95%
No Match	$\leq$ 5%	$\leq$ 5%

Unsubstantiated (Not in Medical Record)	≤ 2%	≤ 2%

When specific performance issues become apparent through any other monitoring and analysis process, PRSN staff may require system level problem solving, including a formal request for a corrective action plan. The PRSN has policies and procedures in place to request corrective action plans from providers and subcontractors. (See PRSN Policy 9.09 Corrective Action Plan) The PRSN staff is responsible to monitor that providers have effectively implemented corrective action plans. PRSN staff may also provide technical assistance, collaboration, and leadership regarding effective clinical practices and adherence to statutes through meetings with Clinical Director's, DMHPs, the UMC, and clinical staffing meetings as a means towards system improvement. Providers will provide a status of corrective action implementation at quarterly QUIC meetings.

REVIEW OF QUALITY MANAGEMENT PLANS AND STRATEGIES

The quality management plan is reviewed at least annually. The necessity for quality management plan changes are identified through QUIC meetings and quality management activities described in this plan. Information, analysis, trends and recommendations are reported monthly to the Advisory Board.

The quality management plan may be revised by PRSN staff upon recommendation of the QUIC. Such recommendations are based on data and analysis from the full range of quality assurance activities, including results from the Performance Improvement Projects, results received from external quality reviews, and The Department reviews. Changes to the plan must also occur when required by contract obligations or changes in relevant statutes. Examples of revisions that may occur include, but are not limited to:

- **Revision of the Quality Indicators:** The Quality Indicators focus on the clinical and non-clinical objectives with the intent to measure and improve overall, sustainable quality within the system. The QUIC is responsible for incorporating the analysis of Quality Indicator results into the quality improvement activities conducted by the PRSN. Existing Quality Indicators may be modified, or additional quality indicators may be developed and incorporated.
- **Revision of the Quality Improvement Work Plan:** The Quality Improvement Work Plan is a document that provides a summary and general timeline for all quality assurance activities. This may be revised to reflect any other changes in the overall plan.
- **Revision of any other aspect of the overall Quality Management Process:** Any other process, such as the processes used for monitoring or incorporating feedback may be revised through this process.

All changes to the plan are submitted to The Department for approval prior to implementation. The approved Quality Management Plan is then disseminated to providers and other stakeholders within the network.

Network service providers are required to develop a Quality Management Plan unique to their agency. Expectations for these plans are informed by regional trends, unique trends or characteristics of each agency, contract requirements, and relevant statutes. The PRSN evaluates provider plans for objective and measurable performance indicators. The plans are approved by the PRSN and monitored through the annual Administrative Review process.

PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: REHABILITATIVE AND INTEGRATED MENTAL HEALTH TREATMENT FOR CHILDREN, ADULTS, & OLDER ADULTS **Policy Number:** 2.08

Reference: DSHS Contract, WAC 388-877-0200, 42 CFR 438

Effective Date: 10/2005

Revision Date(s): 12/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Form: PRAT
- Plan: Compliance Plan
- Policy: Culturally Competent Services
- Policy: Intake Assessment and Evaluation Services Standards
- Policy: PRSN or Provider Use of Federally Excluded Providers
- Policy: Service Provider Selection
- Policy: Service Provider Licensing Procedures
- Policy: Special Needs Accommodation Process

PURPOSE

The Peninsula Regional Support Network (PRSN) will provide rehabilitative and integrated mental health treatment services to children, adults, and older adults as determined to be medically necessary and recommended by a Mental Health Professional (MHP). The medically necessary mental health services will be coordinated and furnished by a licensed network community mental health agency.

DEFINITIONS

Adult is defined as an individual on or after their eighteenth birthday.

Child is defined as an individual who has not reached their eighteenth birthday. For persons eligible for the Medicaid program, the term child extends to individuals that have not reached their twenty-first birthday.

Community Mental Health Agency (CMHA) means a behavioral health agency certified by the department and contracted by the PRSN to provide a mental health services.

Integrated Mental Health Services are defined as services that are coordinated to include multiple service providers.

Medical Necessity is a term used to describe 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 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.

Mental Health Professional (MHP) means a designation given by the department to an agency staff member who is:

1. A psychiatrist, psychologist, psychiatric advanced registered nurse practitioner (ARNP), or social worker as defined in chapters 71.05 and 71.34 RCW;
2. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, that was gained under the supervision of a mental health professional and is recognized by the department;
3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
4. A person who had an approved waiver to perform the duties of a mental health professional (MHP), that was requested by the regional support network (RSN) and granted by the mental health division prior to July 1, 2001; or
5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the department consistent with WAC 388-865-0265.

Older Adult is defined as an individual who is sixty years of age or older.

PROCEDURE

1. The PRSN recognizes an effective and efficient mental health service delivery system requires that the PRSN contract with comprehensive community mental health agencies that are able to provide the continuum of various types of recovery-based services in a seamless and integrated manner.
2. The PRSN ensures when two or more mental health providers are delivering mental health rehabilitation services to seriously mentally ill adults and seriously

emotionally disturbed children with Medicaid, the services are provided in an integrated and culturally sensitive manner. Reference the PRSN policy: Culturally Competent Services

3. The PRSN contracts with comprehensive community mental health agencies in order to ensure the full array of required services are available and provided in a integrated and developmentally appropriate manner for children, adults and older adults. Reference PRSN policy: Service Provider Selection
    a. The PRSN contracts with multiple licensed community mental health agencies and providers that utilize evidence based, research based, consensus based, and promising practice models that are designed to target the individual populations served by the PRSN.
    b. If an individual presents with a unique need that requires medically necessary services that the assigned PRSN community mental health agency can not provide, the PRSN coordinates the service delivery within the network with another community mental health agency or out of network provider that does provide the service.
    c. The PRSN maintains a special needs accommodation process to ensure that all Medicaid individuals served by the PRSN have access to care. Reference PRSN policy: Special Needs Accommodation Process
    d. Mental health services are recommended by a mental health professional.
        - For children and youth and older adults, the mental health professional is a child or geriatric mental health specialist or in consultation with the appropriate mental health specialist.
        - For minorities and developmentally and physically disabled individuals, the mental health professional makes a recommendation in consultation with a minority and/ or disabled specialist.
        - A request for the recommended services is submitted to the PRSN Utilization Management contractor, CommCare, to make the service authorization determination utilizing the PRSN adopted authorization care standards.
4. The PRSN maintains a network of state licensed comprehensive community mental health agencies that provide a full array of mental health rehabilitative services. Reference PRSN policy: Service Provider Licensing Procedures
    a. The PRSN only contracts with agencies that are licensed to provide mental health services in the state of Washington.
        - Exception: Mental Health Clubhouses do not have to be licensed by the state of Washington to contract and provide services to individuals, per state definition. The state of Washington may require Mental Health Clubhouses to adhere to specific contract language, such as certification.
    b. The PRSN requires the network community mental health agencies to maintain personnel files that include current professional licenses, primary source proof of credentials, training records, annually updated performance

evaluation, and proof of unimpeded license as evidenced by a printout from the OIG federal exclusion website. Reference PRSN policy: PRSN or Provider Use of Federally Excluded Providers

- Any negative action taken by a licensing body against a PRSN contracted community mental health agency provider must be reported to the PRSN Compliance Officer, per contract and the PRSN Compliance Plan. Reference PRSN Plan: Compliance Plan
- In the event action is taken against a contracted network community service agency's license, the PRSN must be immediately notified per contract. The PRSN review and disposition of the event/ action is based upon processes outlined in the current contract.

5. The PRSN ensures services recommended, authorized, and provided are deemed to be medically necessary and recommended by a mental health professional.
   a. The PRSN network community mental health agencies and utilization management contractor, CommCare, must adhere to PRSN adopted Access To Care standards, that include the state defined medical necessity criteria and access to care standards.
      - The PRSN authorization tool requires the provider to request and the authorization determination to be identified on the same screen/ page of the tool (inpatient, outpatient, and residential tools). This allows for a quick and standardized reference to the medical necessity criteria and how it applies to each individual seeking services.
   b. The PRSN audits each network community mental health agency to ensure services provided adhere to and adequately document the criteria of medical necessity, as defined and listed above.
      - The PRSN conducts a minimum of 500 clinical (blended comprehensive and targeted) chart reviews per year to ensure the medical necessity standards are consistently applied.

MONITORING

This policy is mandated by contract and statue.

1. This policy is monitored through the use of the PRSN:
   - Annual Provider Chart Reviews
   - Over and Under Utilization Projects
   - Grievance Tracking Reports
   - Utilization Management Committee activities and reports for trends such as (authorization and denial) determinations, trends for denial decisions, identifying medical necessity trends (incongruence patterns), and other relevant reporting.

- Annual PRSN Provider and Subcontractor Administrative Review
- Quarterly Provider Performance Reports

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

PENINSULA REGIONAL SUPPORT NETWORK
Providing Public Mental Health Services in
Clallam, Jefferson, and Kitsap Counties

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Anders Edgerton

MEMORANDUM

To: **Stacey Devenney, Chief Clinical Officer**
Lavonne Fachner, Quality & Utilization Director
Ellie Carrithers, 24 Hour Services Program Manager

From: **Richard VanCleave, Clinical Manager Peninsula RSN**
Toby Bingham, Children's Services Coordinator, Peninsula RSN

Date: **8/18/2015**

Re: **Review of Kitsap Mental Health Services Adult and Youth Inpatient Units and Keller House RTF**

Peninsula RSN recently reviewed the Adult and Youth Inpatient Units (AIU and YIU) and the Keller House residential program operated by Kitsap Mental Health Services. The full review results can be found at:

[drive]:\KMHS\CHART REVIEWS\FY 14-15 REVIEWS\E&T and RS FY 14-15

AIU and YIU Chart Review

The review of charts included 20 consumers who were at the AIU/YIU. There were no areas below compliance for the YIU.

At the AIU, almost all areas met expectations, with the following exception:

- AIU: The prescriber attempted to obtain informed consent for medications. 388-865-0570 (1)(a) (**56%**). This score has been below compliance for five consecutive years, with this year's score being the lowest.

Keller House Chart Review

The RSN reviewed charts for ten individuals who had been at Keller House during FY 2014-15. The following areas were below compliance.

- Evidence that efforts are being made to help the resident learn independent living skills in order to eventually move to a lower level of care. (**0%**) The daily residential treatment notes (shift notes) are very thorough in documenting the consumer's behavior. However, they rarely make any mention of treatment provided. It has been a particular focus of EQRO and DBHR that every encountered service must have associated documentation demonstrating actual treatment provided, not just observations of the consumer's actions during the treatment period.
- The treatment plan includes a goal addressing the residential treatment needs, interventions, and outcomes. (**80%**)
- The individual has a current crisis plan. (**80%**)

REQUEST FOR CORRECTIVE ACTION PLAN

Please submit a corrective action plan that address how the agency will:

- Keller House: Document actual treatment provided during encountered services.
- Keller House: Ensure that all consumers receiving residential treatment have a crisis plan and a treatment plan goal addressing the residential treatment needs, interventions, and outcomes.
- AIU: Ensure that prescribers attempt to obtain consent prior to starting the individual on medications.

Please contact us with any questions or concerns about the results. I can be reached at (360) 307-4275.

cc: RSN

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Anders Edgerton

MEMORANDUM

To: **Adam Marquis, Executive Director, JMHS**
Erik Nygard, Clinical Director, JMHS
Tonya Ferguson, Director of Operations/HR, JMHS

From: **Richard VanCleave, Clinical Services Manager, PRSN**

Date: **3/18/2015**

Re: **Fiscal Year 2014-15 Clinical Chart Review (Adult)**

The RSN recently completed a review of 60 consumer charts at JMHS. The audit sample included the records of consumers who received one of the following during 2014-15:

- An initial authorization or reauthorization.
- A crisis service
- An intake but not authorized (Zero PRATs)

The results of the audit are outlined below. The detailed results are in the shared drive under [drive]:\JMHS\CHART REVIEWS\FY 2014-15 Reviews\FY 2014-15 Adult Chart Review

There were 16 areas below compliance this year, with 15 areas requiring a corrective action plan. This is a significant increase over previous years (six areas below compliance in 2014, nine in 2013).

Intake

Ten intake/authorized for care charts were reviewed. The following areas were below compliance:

- The intake includes sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM) criteria (80%).
- If routine service did not occur within 28 days there is adequate documentation explaining why (80%).
- If the client did not receive a first routine appointment within 28 days, engagement efforts were adequate and appropriate to the consumer (0%). One example, indicated by the purple tab in the spreadsheet (in the shared drive, above): The client had a serious suicide attempt a few days before the intake. When he did not

show for his first appointment, there is no indication in the record that any attempt was made to contact him.

Zero PRATs (Intake/not authorized for care)
Ten Zero PRAT charts were reviewed. The focus of the review was on the appropriateness of the decision to not request authorization and whether appropriate referrals to other services were made. The review also covered other basic intake requirements. The following areas were below compliance:

- The intake includes sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM) criteria. (70%)
- Assigned Level (Not Authorized for Services) is appropriate for client's diagnosis, symptomatology, and service needs and adheres to the guidelines in the current PRSN's Levels of Care. (55%)

Reauths/Ongoing Care
Ten continuing-care charts were reviewed. The following areas were below compliance:
Treatment Plans

- Treatment plan goals are based on the intake assessment and diagnosis (or based on an updated assessment of consumer). (70%)
- The treatment plan was reviewed every 180 days. (60%)
- The 180 day review includes a narrative justification for continued treatment at the level of care requested. (56%)
- The plan demonstrates the individual's participation in the development of the individual service plan using quotes. (67%)
- Includes treatment goals that are measurable. (67%)
- The person has a crisis plan when required (0%)

Progress Notes

- If a service occurs, the service references an intervention on the treatment plan. (40%)
- Notes identify treatment goal being addressed, and this goal is reflective of treatment plan. (55%)
- The consumer is receiving other services listed in WAC 388-877A-0100 (2) and is therefore not "meds only". (50%)
- The frequency of service and type of service utilized is the best fit for this client, given the documented description of their clinical presentation in the treatment notes, and in the intake if it was completed within the previous year. (56%)

Crisis Review
The crisis intervention audit included 20 consumers who had either:

- Qualified as a High Utilizer (readmission within 30 days of discharge from an inpatient stay)
- Been evaluated for involuntary or voluntary hospitalization, or
- Had a crisis services phone call only

The only area requiring a corrective action in this section was:

- Did the agency have contact with the hospital within 3 days of admit for the purposes of discharge planning and coordination. (63%)

REQUEST FOR CORRECTIVE ACTION

Please submit a corrective action outlining how you will ensure that:

- All intakes (both authorized and not authorized for care) include sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM) criteria.
- If routine service does not occur within 28 days there is adequate documentation explaining why.
- If the client does not receive a first routine appointment within 28 days, engagement efforts are adequate and appropriate to the consumer.
- For Zero PRATs, the assigned level (Not Authorized for Services) is appropriate for client's diagnosis, symptomatology, and service needs and adheres to the guidelines in the current PRSN's Levels of Care.
- Treatment plan goals are based on the intake assessment and diagnosis (or based on an updated assessment of consumer).
- Treatment plans are reviewed every 180 days.
- The 180 day review includes a narrative justification for continued treatment at the level of care requested.
- The plan demonstrates the individual's participation in the development of the individual service plan using quotes from the individual.
- Treatment goals are measurable.
- The person has a crisis plan when required.
- If a service occurs, the service is an intervention on the treatment plan.
- Notes identify treatment goal being addressed, and this goal is reflective of treatment plan.
- When receiving medication management, the consumer is receiving other services listed in WAC 388-877A-0100 (2) and is therefore not "meds only".
- The frequency of service and type of service utilized is the best fit for this client, given the documented description of their clinical presentation in the treatment notes, and in the intake if it was completed within the previous year.
- The agency has contact with the hospital within 3 days of admit for the purposes of discharge planning and coordination.

Please provide information on how **each of these** will be met with a time frame for each.

Corrective action plans are due within 30 days of the receipt of this letter.

Please contact me with any questions or concerns about the results. I can be reached at (360) 307-4275.

Cc: Anders Edgerton, Martha Crownover, Michelle Alger, Toby Bingham

PRSN

PENINSULA REGIONAL SUPPORT NETWORK
Providing Public Mental Health Services in
Clallam, Jefferson, and Kitsap Counties

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MEMORANDUM

To: Peter Casey, Executive Director, PBH

Wendy Sisk, Clinical Director, PBH

From: Richard VanCleave, PRSN

Date: 2/11/15

Re: Annual Chart Review

Peninsula RSN recently completed an annual review of adult outpatient charts at PBH. For the current audit, the RSN reviewed 85 adult consumer charts covering a variety of topics. The review included charts for consumers who had either:

- An intake (both authorized and Zero PRATs)
- A reauthorization
- A crisis intervention

The results of the review are outlined below. Results for each chart reviewed can be found in the shared folder at: [DRIVE]:\PCMHC\CHART REVIEWS\CHART REVIEWS FY 2014-15\Adult PBH Outpatient Review 2014-15

Intake Review

Overall, the intakes were well done and had all of the required documentation. The three areas below compliance had to do with timelines:

- The full treatment plan was developed within thirty days from the first session following the intake evaluation. (80%, down from 100%)
- If routine service did not occur within 28 days there is adequate documentation explaining why (50%, down from 100%).
- If the client did not receive a first routine appointment within 28 days, engagement efforts were adequate and appropriate to the Consumer (67%, down from 100%)

Regarding the last two, only nine of the 15 clients received their first service within 28 days of the request for service. In almost all cases, it appears this was due to the intake being scheduled so far out (making it very difficult to meet the 28 day rule). There were examples of clients being offered a walk-in appointment, but if they refused they were then given an appointment more than 10 days out.

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The average days between request and intake was 14.53 (last year it was 7.7 days).

The average days between request and first service was 28 days (16.9 last year).

Reauthorization Review
In most cases, the treatment provided was based on the assessment and the treatment plans and progress notes contained the required information. The following were the only areas below compliance:

- The treatment plan was reviewed every 180 days. (80%, down from 90%)
- The 180 day review includes a narrative justification for continued treatment at the level of care requested. (87%, down from 90%)
- Treatment goals were measureable. (83%, was 85% last year).

The medical provider notes contained all of the required information and statements of consent, and the one LRA client in the sample had the required rights and monthly monitoring.

One area of concern that will not require a corrective action but might be an issue next year (when it will be included on the audit tool) is the requirement that clinicians answer the following question at every treatment plan review: "Describe any changes in the individual's functioning or life circumstances during the review period" This was meant to cover the "intake update" requirement that the EQRO placed on the RSN. A brief sample of statements in this area during this review showed incomplete sentences that did not address the question (I can provide examples).

Review of Consumers Not Authorized (Zero PRATs)
As in previous years, there were no areas below compliance. The documentation demonstrated that the individuals did not meet access to care standards and that appropriate referrals were made.

Review of Crisis Intervention Services
Most crisis notes demonstrated thorough documentation. There were two areas below compliance:

- Were safety needs and risk factors adequately addressed? (85%, down from 100%). This was a problem in previous years—although not for the last two reviews. It is important that crisis notes clearly document that safety was assessed.
- Contact with the liaison or hospital treatment team occurs within three working days of an enrolled consumer's admission to the hospital. (55%, down from 70%). This has been a finding for five consecutive years.

REQUEST FOR CORRECTIVE ACTION PLAN

Note: The corrective action thresholds are set by the QUIC workgroup and are as follows:

Sample size	Corrective Action (if below)
2 to 5	50%
6 to 9	70%
10+	90%

Please submit a corrective action plan that outlines how you will ensure that:

- The full treatment plan is developed within thirty days from the first session following the intake evaluation.
- If routine service did not occur within 28 days there is adequate documentation explaining why.
- If the client did not receive a first routine appointment within 28 days, engagement efforts were adequate and appropriate to the consumer.
- The treatment plan is reviewed every 180 days.

- The 180 day review includes a narrative justification for continued treatment at the level of care requested.
- Treatment goals are measureable.
- Contact with the liaison or hospital treatment team occurs within three working days of an enrolled consumer's admission to the hospital.
- Safety needs and risk factors are adequately addressed.

Corrective action plans are due within 30 days of the receipt of this letter.

Please contact me with any questions or concerns about the results. I can be reached at (360) 307-4275.

Cc: RSN

PENINSULA RSN

PROVIDER MONITORING POLICIES AND PROCEDURES

Policy Name: MONITORING OF CONTRACTORS **Policy Number:** 9.02

Reference: 42 CFR 438.201, 206, 207; WAC 388-865-0284; DSHS Contract

Effective Date: 8/2004

Revision Date(s): 2/2013

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Plan: Quality Management Plan
- Policy: Corrective Action Plans
- Policy: Provider and Subcontractor Administrative Review

PURPOSE

The Peninsula Regional Support Network (PRSN) shall monitor contracted providers for compliance with contract requirements and state and federal regulations.

PROCEDURE

1. The PRSN monitors contractor compliance and performance by a variety of means
    - Contractor licensing and certification is monitored during the annual PRSN administrative reviews.
    - Statistical monitoring is performed quarterly in the PRSN performance reports.
    - Contractor performance is compared to statewide standards on specific performance measures.
    - Timely access to services is monitored through MIS data reports.

- A random sample of clinical files is reviewed annually, at a minimum totaling 500 charts in a year.
- A standardized clinical chart review is utilized, as well as targeted/ focused chart reviews such as Practice Guidelines and zero PRATs.
- Files are reviewed for data accuracy against the PRSN database.
- Grievance reports are complied quarterly and monitored for patterns of grievances that bears investigation by PRSN staff and the Quality Improvement Committee.
- PRSN monitors and oversees the agency semi-annual revenue and expense reports submitted to the PRSN.
- PRSN conducts annual delegation agreements/plan reviews.

2. The PRSN conducts annual PRSN provider and subcontractor administrative reviews, targeting areas of trend and corrective action from previous reviews.

   The PRSN will:

   - Deliver to the provider copies of the format of the review at the time of review, or earlier.
   - Report the results of the review in writing to the provider, including areas needing improvement or other acts of non-compliance, within 30 calendar days of the completion of the review.
   - Identify required redress or repair and the time limits, and the form or format or other evidence that the provider is required to submit in order to be considered compliant.
   - Report to the provider the possibility of punitive response as may result from failure to comply.

3. Contractor performance on statewide data collection programs is monitored.
   - MHSIP results are monitored for each agency, annually.
   - The PRSN requests the Washington Institute for Mental Illness Research and Training to over-sample our contracted providers, per survey event.

MONITORING

1. This policy is a mandate by contract and statue. This policy is monitored through use of PRSN:
   - Annual PRSN Provider and Subcontractor Administrative/ Subdelegated Review
   - Annual Provider Chart Reviews
   - Grievance Tracking Reports

- Biennial Provider Quality Review Team review
- Quarterly Provider Performance Reports
- Quality Management Plan activities, such as review targeted issues for trends and recommendations.
- Review of previous provider corrective action plans related to the Age and Cultural Competence policy, including provider profiles related to performance on targeted indicators.

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

PRSN MONITORING TABLE
FY 2015 Activities

Monitoring Activity	PRSN Contractor	Due Date	Date Activity Completed
Grievance Tracking Reports analysis and network grievances submitted to Department	PRSN	May 15	
PRSN Gaps Analysis	PRSN		9/01/05
Provider R & E Reports		September	
Clinical chart reviews:	Network	Annual	
PRSN Subcontractor Admin. Review	Ombuds	Winter	
Provider Performance Reports – (previous FY Totals)		October	
1st QRT On-Site Provider Review		Fall	
Grievance Tracking Reports analysis and network grievances submitted to Department	PRSN	November 15	
Provider Performance Reports- 1st Qtr of current FY		December	
PRSN Provider Admin. Review	KMHS	January	
Provider R&E Reports		February	
PRSN Provider Admin. Review	JMHS	February	
Provider Performance Reports- 2nd Qtr of current FY		March	
2nd QRT On-Site Provider Review		Spring	
PRSN Provider Admin. Review	PBH	April	
PRSN Provider Admin. Review	WEOS	June	
Provider Performance Reports-3rd Qtr of current FY		June	
Provider Performance Reports- 4th Qtr of current FY and Yearly Totals		September	
QUIC Review Provider QM Plans and QA Reports		Annual	

Monitoring Activity	PRSN Contractor	Due Date	Date Activity Completed
PRSN Fiscal Review of each Provider Agency		Annual	
PRSN Subdelegated Admin. Review: ASO	ASO	Biennial	
PRSN Subdelegated Admin. Review: KMHS IS	IS	Biennial	
PRSN Review of E&Ts	AIU & YIU	Annual	
PRSN Review of Residential Programs	KMHS & PBH	Annual	
Provider Performance Reports- 4th Qtr of current FY and Yearly Totals		September	

PENINSULA RSN

ADMINISTRATION POLICIES AND PROCEDURES

Policy Name: CONSENT FOR TREATMENT **Policy Number:** 2.12

Reference: WAC 388-877A-0100, -0120 (Outpatient), 388-865- 0550 through –0560 (Inpatient)

Effective Date: 8/2003

Revision Date(s): 12/2012

Reviewed Date: 12/2014

Approved by: PRSN Executive Board

CROSS REFERENCES

- Policy: Enrollee Rights
- Policy: Corrective Action Plan

PURPOSE

The Peninsula Regional Support Network (PRSN) shall ensure consent for treatment is uniformly provided throughout the provider network.

PROCEDURE

The PRSN promotes customer satisfaction by requiring providers to assure informed consent to treatment, and consumer access to a consumer's own records, as follows:

1. Obtain general consent to treatment of all consumers.
2. Minors over twelve years of age may request and receive treatment without parental consent.
    - Parents may request Parent-Initiated Treatment for inpatient and outpatient assessment for on-going treatment.
3. Grant requests to review a consumer's own records within fifteen days (as indicated in WAC 388-865-0435).
4. Reviewing the file to remove any material confidential to another person.

5. Allowing the consumer sufficient time and privacy to review the record, and providing at consumer request a clinical staff member to answer questions.
6. Permit persons requested by the consumer to also be present.
7. Assess a reasonable and uniform charge for reproduction of the file, if so desired.
8. Specifically obtain written informed consent of the consumer or legally responsible other before use of medication, use of unusual diagnostic or treatment procedure, use of audio or visual devices to record the consumer's behavior, and before the consumer is the subject of research.
9. File written consent forms in the consumer's file.

MONITORING

This policy is a mandate by statue.

1. This Policy will be monitored through use of PRSN:
   - Annual PRSN Provider and Subcontractor Administrative Review
   - Annual Provider Chart Review
   - Grievance Tracking Reports
   - Biennial Provider Quality Review Team On-site Reviews
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval. Reference PRSN Corrective Action Plan Policy.

SALISH BEHAVIORAL HEALTH ORGANIZATION: QUALITY INDICATORS FY 15

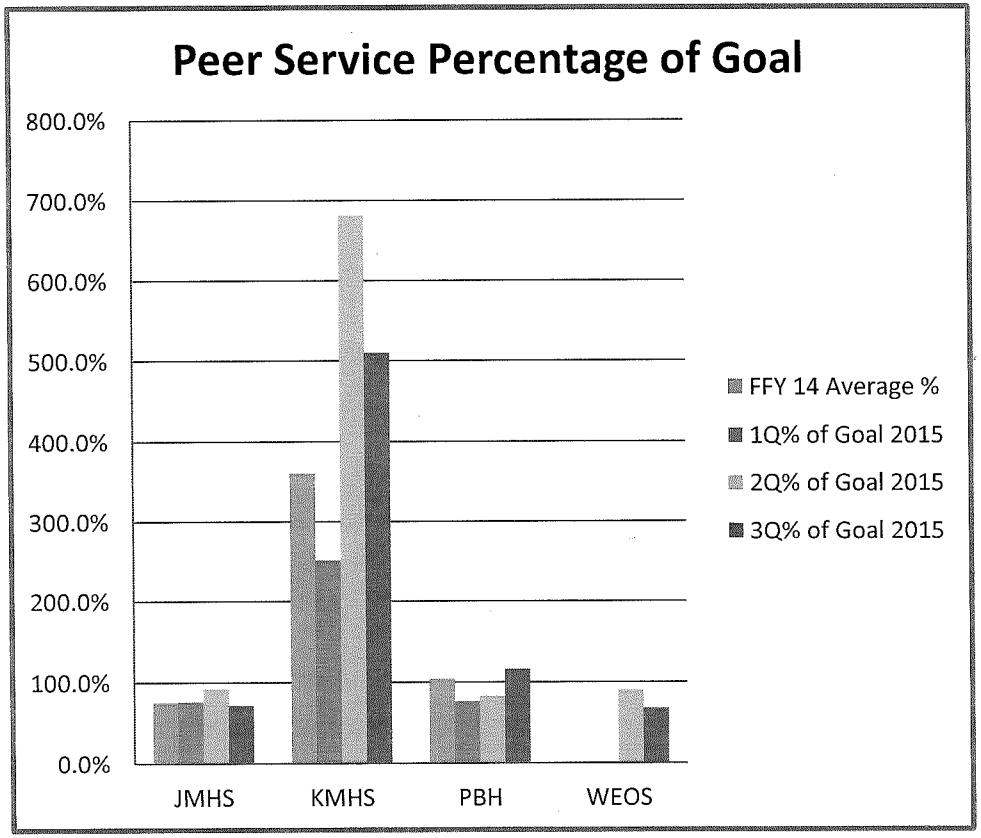
*** Core performance measures required and measured by The Department in 09-11 contract years**
**** Submitted to The Department as Regional Performance Measures**

Definition of Indicator and Measurement Standard

1. Peer Services

Peer service hours encountered for Medicaid funded individuals by each agency for the specified time frame.

Data source: Profiler, T19 county stats report



Measurements

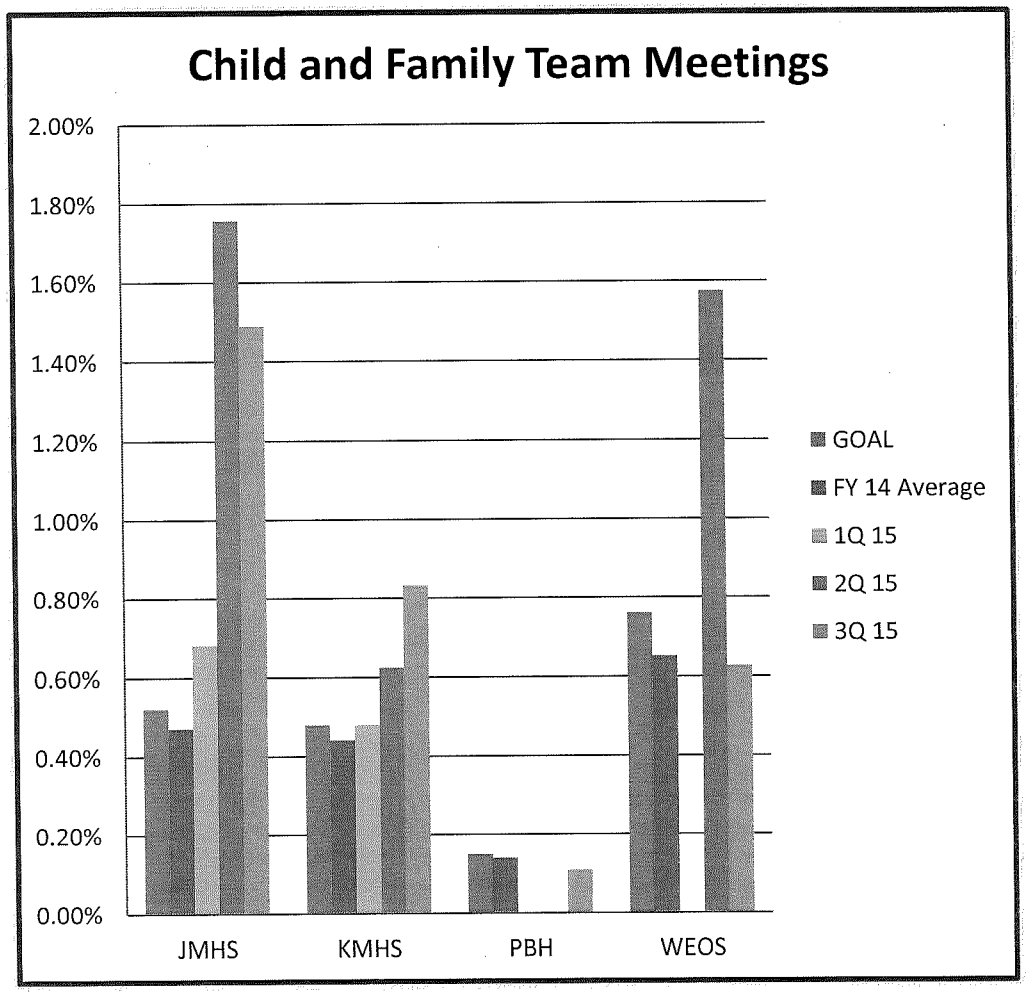
	Region	JMHS	KMHS	PBH	WEOS
Quarterly GOAL	**1384.85**	15	42.3	1311.72	15
4th SFY 2013 measure	**1191.71**	13.75	37.33	1140.63	0.0
1Q 2014	**1987.6**	18.8	63.8	1905	0.0
2Q 2014	**1514.9**	8.3	121.0	1385.7	0.0
3Q 2014	**1014.5**	8	163.8	842.7	0.0
4Q 2014	**1354.7**	8.3	160	1304.5	0.0
1Q 2015	**1118**	12	106.3	999.6	0
2Q 2015	**1247.4**	12.1	224.1	998.9*	12.3
3Q 2015	**1758**	11*	216	1521	10*
Notes:					

Target: 15% increase from baseline

2. Child and Family Team Meetings

Child and family team meetings encountered using the HT modifier by each agency and by number of children and youth services encountered for the time frame.

Data source: Profiler, RSN Encounter Data Validation report



	Region	JMHS	KMHS	PBH	WEOS
GOAL	0.43%	0.52%	0.48%	0.15%	0.76%
SFY 1Q 2014	**0.23%** 27/9027	0.52% 5/965	0.27% 18/6657	0.0% 0/1111	1.4% 4/294
2Q 2014	**0.46%** **(47/10116)**	0.46% (6/1307)	0.48% (34/7022)	0.21% (3/1458)	1.22% (4/329)
3Q 2014	**.49%** 44/8955	.48% 5/1032	.54% 34/6340	.36% 5/1374	0.0% 0/209
4Q 2014	**.39%** 44/11399	.42% 5/1182	.47% 39/8320	0.00% 0/1444	0.00% 0/453
1Q 2015	**.39%** **35/7321**	.77% 6/782	.44% 29/6616	0.00% 0/1328	0.00% 0/215
2Q* 2015	**.65%** **70/10706**	1.76% 16/911	.62% 50/8014	0.0% 0/1527	1.57% 4/254
3Q 2015	**.77%** **97/12581**	1.49% 14/940	.83% 79/9497	.11% 2/1825	.63% 2/319
Notes:					

Numerator: Number of child and family team meetings (using the HT modifier) that are recorded for children and youth under the age of 21 in the time range.

Denominator: Total number children and youth services (under the age of 21) encountered in the time range.

*** Target goal was set during this quarter**

3. Inpatient Utilization (readmission rate)

Readmission rate to inpatient services

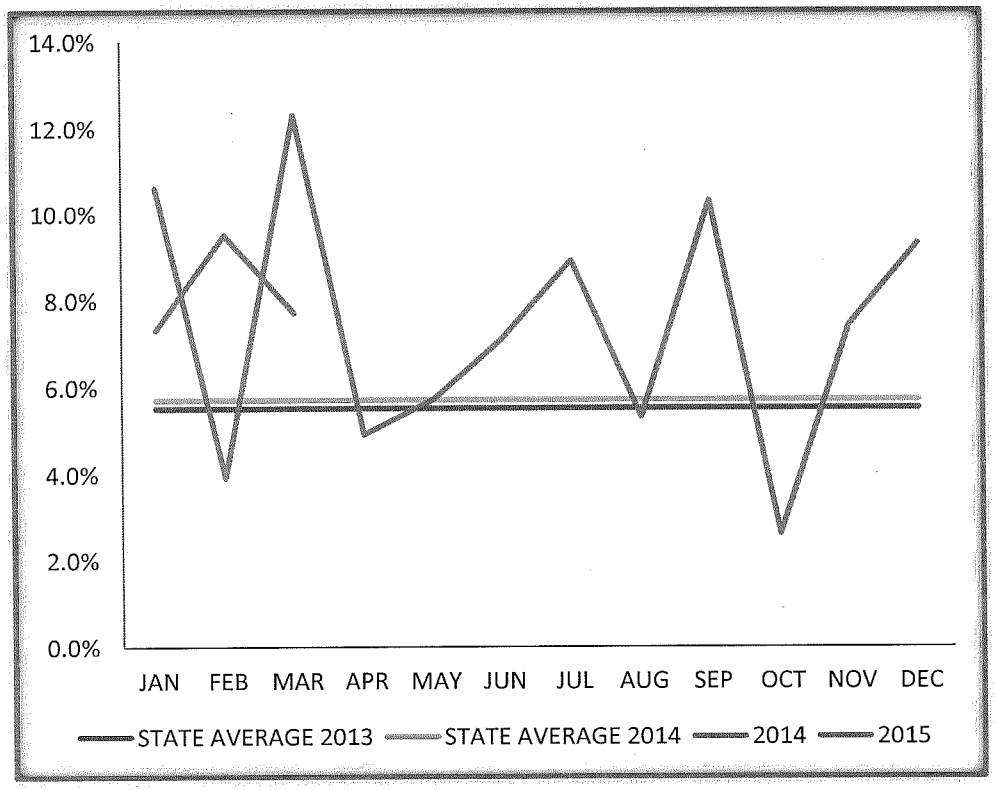
Numerator: Number re-admitted to inpatient services within 30 days from discharge.

Denominator: Number of individuals discharged from inpatient services during the reporting period

Minimum Performance Standard= Within 2 points of the State's average for previous fiscal year

State's Average for **FY14= 5.7%,** FY13= 5.5%, FY12= 6.1%, FY11=6.3 FY10= 6.9, FY09 = 6.9, and FY08= 7.4

Data source: CommCare readmission report



	Region	KMHS	PBH	JMHS	WEOS
JAN 14	**10.6%** **9/85**	7.5% 5/67	18% 2/11	50% 2/4	0.0% 0/3
FEB	**3.9%** **3/77**	5.7% 3/53	0.0% 0/9	0.0% 0/12	0.0% 0/3
MAR	**12.3%** **8/65**	12.2% 5/41	0.0% 0/9	23.1% 3/13	0.0% 0/2
APR	**4.9%** **3/61**	4.5% 2/44	0.0% 0/12	33.3% 1/3	0.0% 0/2
MAY	**5.7%** **4/70**	7.7% 4/52	0.0% 0/9	0.0% 0/6	0.0% 0/3
JUNE	**7.1%** **5/70**	9.0% 4/44	7.0% 1/14	0.0% 0/11	0.0% 0/1
JULY	**8.9%** **6/67**	9.0% 3/33	4.8% 1/21	18.2% 2/11	0.0% 0/2
AUG	**5.3%** **4/76**	4.0% 2/50	10.5% 2/19	0.0% 0/5	0.0% 0/2
SEPT	**10.3%** **8/78**	10.9% 6/55	9.5% 2/21	0.0% 0/2	0.0% 0/0
OCT	**2.3%** **2/77**	1.8% 1/53	5% 1/20	0.0% 0/4	0.0% 0/0
NOV	**7.4%** **4/54**	7.0% 3/43	9.0% 1/11	0.0% 0/0	0.0% 0/0
DEC	**9.3%** **7/75**	10.3% 6/58	11.1% 1/9	0.0% 0/7	0.0% 0/1
JAN 15	**7.3%** **6/82**	11.1% 5/45	4.8% 1/21	0.0% 0/13	0.0% 0/3
FEB	**9.5%** **6/63**	10.2% 5/49	12.5% 1/8	0.0% 0/4	0.0% 0/2
MAR	**7.7%** 6/77	9.3% 5/54	0.0% 0/4	5.6% 1/18	0.0% 0/1

Data notes:

- In 2014 we moved from SFY to CY monthly monitoring and also switched data sources from Pro-Filer and Community Hospital Billings to CommCare.

4. Access (Outpatient Penetration Rates)

The study measures the penetration rates of each agency in providing services to their overall Medicaid population

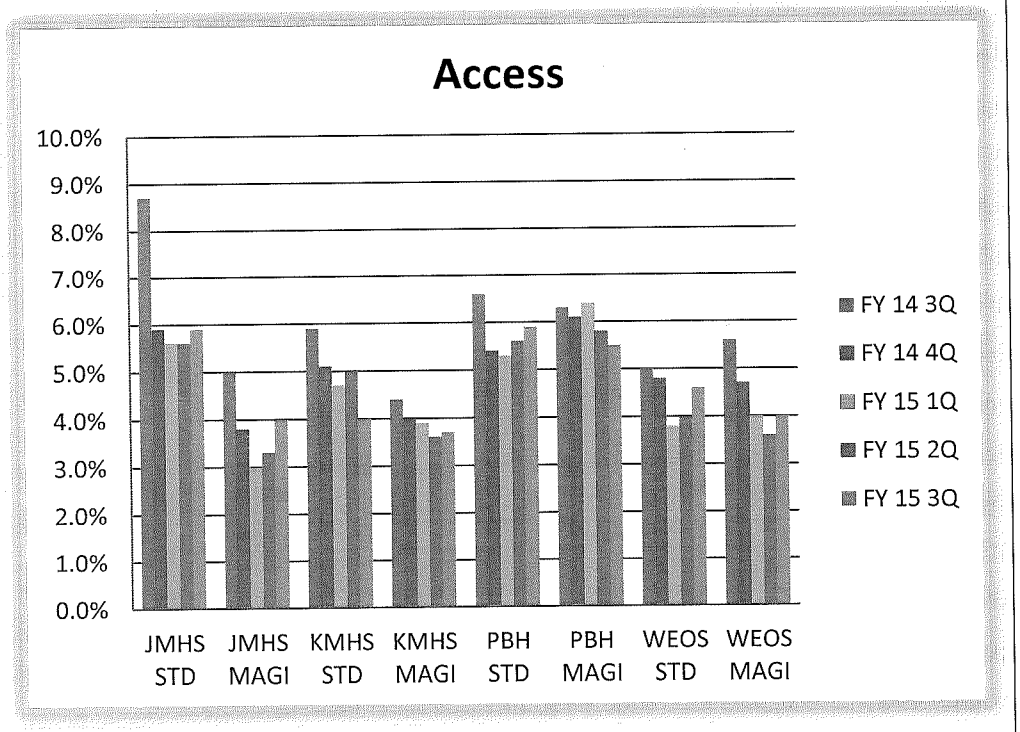
group report.

Numerator: All Medicaid consumers served for the given time frame whose services are funded by Medicaid.

Denominator: Total Medicaid population

Minimum Performance Standard for Region =

Data source: Medicaid eligible population, Pro-filer report for RSN Unduplicated T19 Serviced by Agency and Age



	Region	JMHS	KMHS	PBH	WEOS
FY 14 3Q STD	**6.6%**	8.7%	5.9%	6.6%	5.0%
FY 14 3Q MAGI	**5.3%**	5.0%	4.4%	6.3%	5.6%
FY 14 4Q STD	**5.3%**	5.9%	5.1%	5.4%	4.8%
FY 14 4Q MAGI	**4.7%**	3.8%	4.0%	6.1%	4.7%
FY 15 1Q STD	**4.9%**	5.6%	4.7%	5.3%	3.8%
FY 15 1Q MAGI	**4.3%**	3.0%	3.9%	6.4%	4.0%
FY 15 2Q STD	**5.1%**	5.6%	5.0%	5.6%	4.0%
FY 15 2Q MAGI	**4.1%**	3.3%	3.6%	5.8%	3.6%
FY 15 3Q STD	**5.2%**	5.9%	5.0%	5.9%	4.6%
FY 15 3Q MAGI	**4.1%**	4.0%	3.7%	5.5%	4.0%

*This measure will be changing to include specific Medicaid funding (MAGI vs. Classic) when the data reports can support this query.

☒ Performance-based Measure

5.Coordination of Care (inpatient and outpatient)*

a. Time from discharge from hospital to first non-crisis outpatient services.

Numerator: First non-crisis outpatient services received 7 or fewer days after hospital discharge.

Denominator: Number of hospital discharges of consumers who are Medicaid enrolled.

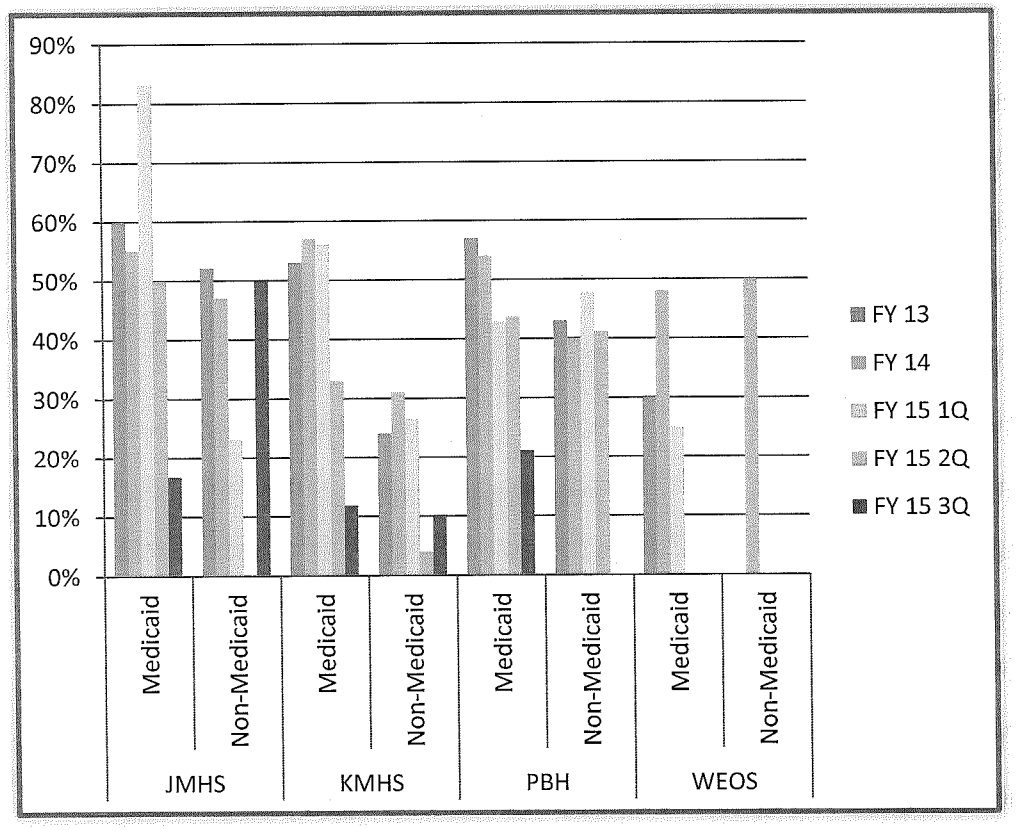
(Minimum Regional Performance target for a 6 month period= 75%)

b. Time from discharge from hospital to first non-crisis outpatient services.

Numerator: First non-crisis outpatient services received 7 or fewer days after hospital discharge.

Denominator: Number of hospital discharges of consumers who are not Medicaid enrolled.

Data source: Profiler custom table- Hospital1srvw_elig_1



	Region	JMHS	KMHS	PBH	WEOS
FY 13 TOTAL Medicaid	52.66%	60%	52.87%	56.72%	30%
	228/433	21/35	166/314	38/67	3/9
FY 13 TOTAL Non-Medicaid	30.25%	51.79%	23.69%	43.29%	0.0%
	121/400	29/56	63/266	29/67	0/8
FY 14 TOTAL Medicaid	56%	55%	57%	52%	50%
	303/545	23/42	227/400	37/71	7/14
FY 14 TOTAL Non-Medicaid	34%	89%	36%	33%	67%
	105/312	40/45	63/176	17/51	2/3
FY 15 1st Medicaid	52.7%	83.3%	56.0%	42.9%	25.0%
	68/129	5/6	47/84	15/35	1/4
FY 15 1st Non-Medicaid	32.9%	23.1%	26.5%	47.8%	NA
	23/70	3/13	9/34	11/23	0.0
FY 15 2nd Medicaid	35.1%	50.0%	32.9%	43.8%	NA
	33/94	½	25/76	7/16	0/0
FY 15 2nd Non-Medicaid	18.2%	0.0%	4.0%	41.2%	NA
	8/44	0/2	1/25	7/17	0/0
FY 15 3rd Medicaid	13.9%	16.7%	11.8%	21.1%	0.0%
	14/101	2/10	8/68	4/19	0/2
FY 15 3rd Non-Medicaid	13.6%	50.0%	10.0%	11.1%	NA
	6/44	2/4	3/30	1/9	0/0
FY 15 4th Medicaid					
FY 15 4th Non-Medicaid					

FY 3Q 2014 we moved to using only Profiler to monitor this performance Measure.

D. To ensure data is accurate and complete and timely.

☒ Performance-based Measure (with slight changes)

7. Data Integrity

Service activity and recipient demographics in the MIS system are compared with documentation in the clinical record.

Data source: Profiler, Encounter Data Validation report

Numerator: Number of aggregate matching service activity and recipient demographics data elements.

Denominator: Total number aggregate Service activity and recipient demographic data elements reviewed.

(Minimum Performance Standard 95%)

Contract Year	Region	KMHS	PBH	JMHS	WEOS
2009/ 2010	97%	97%	96%	97%	98%
2010/ 2011	99%	99%	99%	99%	99%
2011/ 2012	99%	99.3%	97%	99.5%	100%
2012/ 2013	99.7%	99.9%	100%	98.9%	98.4%
2013/ 2014	*97.3%	99.3%	99.9%	99.6%	99.6%

Numerator: Number of unsubstantiated (service cannot be verified in clinical documentation) service activity encounters

Denominator: Total number Service activity encounters reviewed.

(Minimum Performance Standard >2 %)

Contract Year	Region	KMHS	PBH	JMHS	WEOS
2009/ 2010	9.1%	7.0%	15.7%	2.6%	3.2%
2010/ 2011	2.6%	1.2%	1.2%	2.0%	9.5%*
2011/ 2012	1.1%	0.7%	3%	2.9%	0.0%
2012/ 2013	0.7%	0.0%	0.0%	7.8%	0.0%
2013/ 2014	0.5%	.08%	1.4%	0.2%	0.1

For 2009/10, corrective action plans were completed at every agency by December 2010. Plans included staff training, modifications to documentation processes, and elimination or clarification of some code uses.

*Issues with encounters at WEOS for 2010/11 are primarily related to the absence of notes that had not been scanned into Profiler.

*2014- Due to using the state's data with known duration errors, we excluded those errors from the total which resulted in a smaller denominator. This affected the overall numbers.

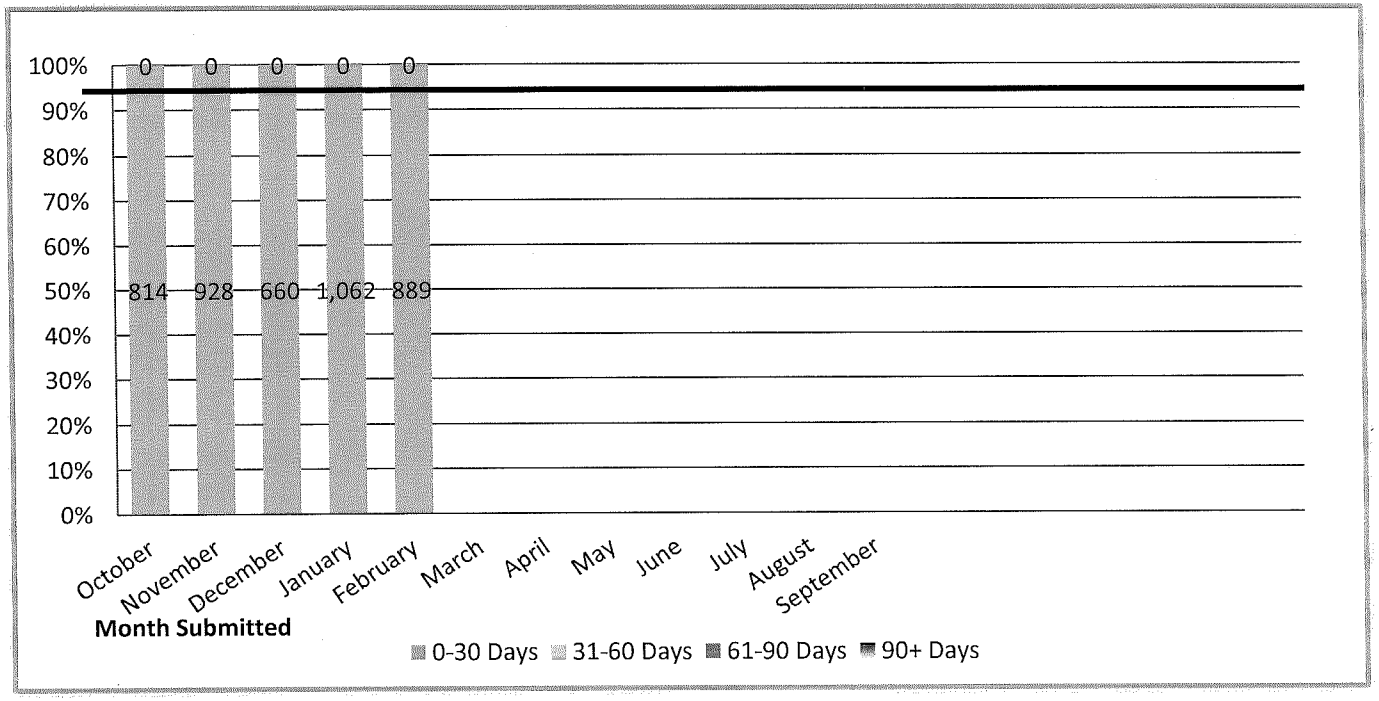
8. Data Integrity * Consumer Periodics submission timeliness

Numerator: Number of Consumer Periodics that were successfully submitted within 60 days of collection.

Denominator: Number of Consumer Periodics that were submitted.

Average of 95%

Data source: DBHR



Contract Year	Cumulative percent for Region
2009/ 2010	100.0%
2010/2011	100.0%
2012/2013	86.8%
2013/2014	100%
Oct 2014- Feb 2015	100%

***Data and graphs provided by DBHR**

**** Months with no data are months when no periodic were submitted.**

9. Data Integrity *

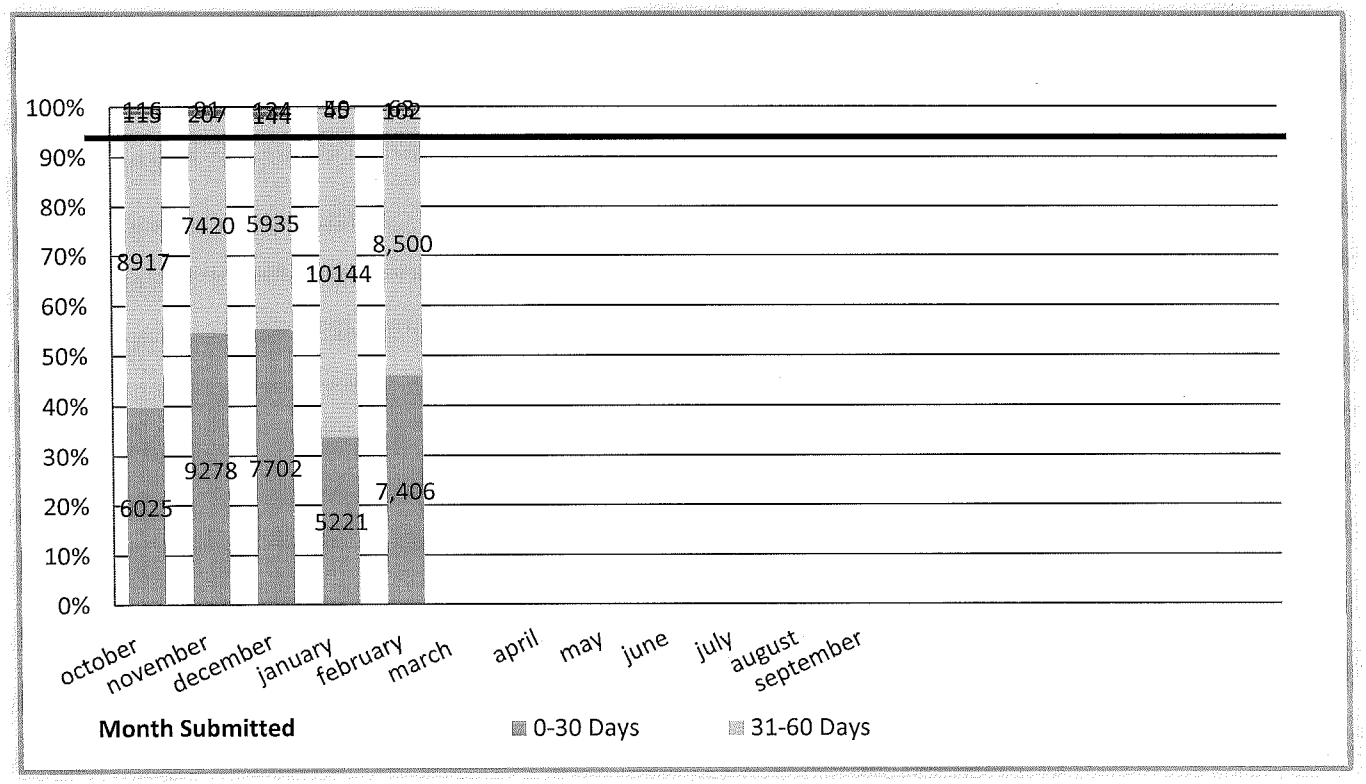
Outpatient encounter submission timeliness

Numerator: Number of outpatient encounters successfully submitted within 60 days after the close of the month in which the services were provided (i.e. service month).

Denominator: Number of outpatient encounters submitted.

Average of 95%

Data Source: DBHR



Contract Year	Cumulative percent for Region
2009/ 2010	26.2%
2010/2011	82.2%
2012/2013	82.4%
2013/2014	95.3%
Oct 2014-Feb 2015	98.6%

*Data and graphs provided by DBHR

SALISH BHO

CHAPTER NAME POLICIES AND PROCEDURES

Policy Name: USE OF EVIDENCE BASED PRACTICES **Policy Number:** 11.15

Reference: DSHS PIHP contract

Effective Date: 2/2013

Revision Date(s):

Reviewed Date: 12/2014

Approved by: SBHO Executive Board

CROSS REFERENCES

- Network Directory: Evidence Based Practices
- Policy: Corrective Action Plan
- Policy: Practice Guidelines
- Policy: Special Populations

PURPOSE

The Salish Behavioral Health Organization (SBHO) encourages network providers to use evidence based practices, attend trainings to increase staff expertise and knowledge, and maintain a list of specialty trained staff.

EBPs have strict and rigid protocol. It is understood that a network provider may use a blend of evidence based practices and utilize key points of a practice to provide high quality services.

DEFINITIONS

Evidence Based Practice (EBP) means a program or practice that has had a multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

- The term "research based" is synonymous with evidence based.

PROCEDURE

The Salish Behavioral Health Organization (SBHO) requires the provider network in subcontracts to participate with the Department to increase the use of evidence based practices (EBPs).

1. The SBHO recognizes the EBPs have rigid protocols that require specific training and associated high costs to implement to fidelity.

2. The Department has contractually focused to increase EBPs for children and youth as identified through legislative mandates. These EBPs include:
    - Trauma-Focused Cognitive Behavioral Therapy (TFCBT/CBT) and CBT-Plus (TF-CBT/CBT+)
    - The network providers are expected to maintain a workforce trained in TF-CBT/ CBT+.

3. The Department encourages the SBHO and network providers to expand the expertise in a multitude of recognized EBPs and research-based practices.
    - The SBHO will continue to provide the recognized list of EBPs and discuss any barriers to implementation and recording of services through the Clinical Directors meetings.

4. The network provider agencies are responsible for recording specific EBPs provided through Profiler.
    - Prior to recording an EBP into the encounter system, the network agency is responsible for ensuring a foundation of fidelity to a particular model.

5. The SBHO will maintain a directory of specialty trained EBP clinicians available in the network.
    - The SBHO Directory of EBP trained clinicians is updated annually and posted on the SBHO website. Reference SBHO Directory of Evidence Based Practices

MONITORING

This policy is mandated by statue and contract.

1. This policy will be monitored through use of SBHO:
    - Annual SBHO Provider and Subcontractor Administrative Review
    - Annual Provider Chart Review
    - Network Directory of Specialty trained network staff

- Monthly SBHO UMC & Clinical Directors meetings

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action Plan will be required for SBHO approval. Reference SBHO Corrective Action Plan Policy.

Peninsula Regional Support Network
Level of Care
Condensed Version

Revised May 2014

Table of Contents

Age Definitions 3

Child and Youth Services 4
Outpatient Level 1 Services: Admission & Continuing Stay 5
Outpatient Level 2 Services: Admission & Continuing Stay 6
Outpatient Level 1 & 2 Services: Expedited Reviews 7
Outpatient Level 1 & 2 Services: Inactivation & Reactivation 8
Inpatient Services: Community Hospital Voluntary & Involuntary 9
Inpatient Services: YIU Voluntary & Involuntary 10
Residential Services: Childrens Long Term Inpatient (CLIP) 11

Adult Services 12
Outpatient Level 1 Services: Admission & Continuing Stay 13
Outpatient Level 2 Services: Admission & Continuing Stay 14
Outpatient Level 1 & 2 Services: Expedited Reviews 15
Outpatient Level 1 & 2 Services: Inactivation & Reactivation 16
Inpatient Services: Community Hospital Voluntary & Involuntary 17
Inpatient Services: AIU Voluntary & Involuntary 18
Residential Services: Brief & Long Term Intensive 19

Adult and Child/Youth Services 20
Crisis & Stabilization Services 21
Respite Services 22

Diagnosis Tables: Reference Access To Care Standards diagnosis tables for Adult (7.03a) and Children/ Youth (7.03b)

Age Definitions

Child: A *child* is defined as a person birth to 12 (twelve) years of age.

Youth: A *youth* is defined as a person 13-17 years of age, requires youth consent.

- For persons eligible for the Medicaid program (with mental health benefits) *and* EPSDT, the term *youth* extends to individuals that have not reached their 21 (twenty-first) birthday.

Adult: An *adult* is generally defined as a person over the age of 18 (eighteen) years.

- For the purposes of residential services, an adult is always defined as a person 18 (eighteen) years or older.

Child & Youth Services

Child and Youth Services
Level 1 Outpatient Services

Service Description

- **Brief Intervention** is a solution focused, outcomes oriented cognitive and behavioral intervention intended to resolve situational disturbances that do not require long term treatment. Authorization benefit: 12 service hours within 6 months, *one time only authorization.*
- **Low Intensity Treatment** is provided to allow a child/ youth and family to continue in treatment to maintain their recovery progress. Functional problems identified in the ISP, include steps that demonstrate on-going treatment progress. This level may be used as a step down from a higher, more intense level of care and authorized for multiple episodes. Authorization benefit: 24 service hours for 12 months.

Routine Admission Criteria

- Individuals must meet the Washington State Access to Care Standards (ACS), and the requested service is determined medically necessary by MHP. ACS include a covered diagnosis, GAF of 60 or lower, and additional criteria if applicable.

EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria may be authorized for Level 2 services:

1. Involved in one or more of the following systems in addition to mental health:
   - Children's Administration
   - Division of Developmental Disabilities
   - Juvenile Rehabilitation or Department of Corrections
2. Diagnosed with Substance Abuse or Addiction
3. Receiving Special Education Services
4. Has a chronic and disabling medical condition
5. As a Medicaid recipient, has previously been authorized for Level 1 services twice.

In addition to the ACS, Non-Medicaid individuals will only be authorized for services if there are sufficient resources and meet ONE of the following criteria:

1. Present with psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from JRA or Juvenile Detention facility
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Under age of 6 years, inadequate caregiver
6. Applied for Medicaid and enrollment decision is pending

Continuing Stay Criteria

- Medicaid individuals can only be re-authorized for **Brief Level 1 services ONCE.**
- Review and documented treatment progress, update ISP, and review / update the crisis prevention plan, as appropriate.
- Requested continued service is determined medically necessary by MHP, and must meet all of the following:
  1. Current ACS covered diagnosis (A or B)
  2. Current symptoms (from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued; and continued treatment is necessary to maintain gains to maintain community safety or to avoid hospitalization.
  3. Intervention is deemed necessary to improve or stabilize functioning (from the covered diagnosis).
  4. The individual is expected to benefit from the intervention(s).
  5. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).
  6. PRSN adopted Practice Guidelines recommend continued treatment.

Type of Services/Modalities

- Intake assessment, group treatment, brief intervention treatment services, individual and family services, medication management, medication monitoring, psychoeducation, and family/ peer supports.

Intensity of Service

- Brief intervention and/ or low intensity mental health services

Duration of Episode

- Brief: Maximum of 12 individuals service hours within 6 months, intended for one time only authorization
- Low Intensity: Maximum of 24 individual service hours for 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA submits a PRAT (identifying the service level, determination of ACS requirements and medical necessity) to PRSN delegated ASO within 14 days from when the intake was initiated.
- ASO reviews PRAT and supporting documentation and then provides an authorization determination within 14 calendar days from the date of the intake assessment beginning. ASO reviews and authorizes extension requests, when indicated.
- Written notification of authorized services is provided via mail.

Child and Youth Services
Level 2 Outpatient Services

Service Description

Long Term Rehabilitation and Children's Intensive Services (CIS) are necessary to improve or maintain stability in the community. Intense level of acute outpatient treatment may include active outreach and home-based services necessary to prevent hospitalization, out of home placement, reinforce personal and community safety and/or decrease the use of other costly services. CIS is the most intensive outpatient authorization for children's services. Authorization benefit: More than 24 service hours up to 12 month authorization episode

Routine Admission Criteria

Individuals must meet the Washington State Access to Care Standards (ACS), and the requested service is determined medically necessary by MHP. ACS includes a covered diagnosis, GAF of 50 or lower and additional criteria if applicable.

EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria may be authorized for EPSDT services:

1. Involved in one or more of the following systems, in addition to mental health:
   - Children's Administration
   - Division of Developmental Disabilities
   - Juvenile Rehabilitation or Department of Corrections
2. Diagnosed with Substance Abuse or Addiction
3. Receiving Special Education Services
4. Has a chronic and disabling medical condition
5. As a Medicaid recipient, has previously been authorized for Level 1 services twice.

CIS. Any Medicaid recipient from 5-17 years of age who meets <u>any two</u> of the following criteria may be authorized for CIS services:

1. Involved in two or more of the following systems, in addition to mental health:
   - Children's Administration
   - Developmental Disabilities Administration
   - Juvenile Rehabilitation or Department of Corrections
   - Receiving Special Education services
   - Involved with substance abuse or chemical dependency services
2. Has been hospitalized for psychiatric care within the last 6 months
3. Three or more crisis contacts in the previous month (to be counted by day)

**** In addition to the ACS, Non-Medicaid individuals will only be authorized for services if there are sufficient resources and meet ONE of the following criteria:**

1. Present with psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from JRA or Juvenile Detention facility.
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Under age of 6 years, inadequate caregiver
6. Applied for Medicaid and enrollment decision is pending

- <u>Safety/ Risk Assessment</u>. In addition to the above criteria, one of the following qualifying risk factors must apply for an individual:
  1. Current severity of symptoms makes the individual at risk for hospitalization, if services are not provided at this level
  2. Child/ youth's placement is at significant risk
  3. More than 3 contacts with the provider crisis team in the previous month
  4. Psychiatric hospitalization in the previous three months
  5. Current suicidal or homicidal ideation, or history of an attempt
  6. Is EPSDT program eligible

Continuing Stay Criteria

- Review and document treatment progress, update ISP, and review/update the crisis prevention plan, as appropriate.
- Medicaid individuals: EPSDT and CIS program requirements are met (listed above in admission) as determined medically necessary by MHP
- In addition to the above criteria, all of the following must apply to an individual, as determined by MHP:
  1. Current ACS covered diagnosis (A or B)
  2. Current symptoms (from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued; and continued treatment is necessary to maintain gains to maintain community safety or to avoid hospitalization.
  3. Intervention is deemed necessary to improve or stabilize functioning (from the covered diagnosis).
  4. The individual is expected to benefit from the intervention(s).
  5. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).

Non-Medicaid individuals: Sufficient resources and continue to meet ONE of the ** additional criteria as determined medically necessary.

Type of Services/ Modalities/ Intensity of Service

- Includes all allowable outpatient services under the state plan; full scope of outpatient treatment modalities.
- EPSDT and CIS can require establishing a formalized Individual Service Team and further development of a Cross-System Treatment Plan.

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists. CMHA submits a PRAT to PRSN delegated ASO within 14 days from when the intake was initiated.
- ASO reviews PRAT and supporting documentation, then provides an authorization determination within *14 calendar days from the date of the intake assessment beginning. ASO reviews and authorizes extension requests.* Written notification of authorized services is provided via mail.

Child and Youth Services
Level 1 & 2 Services
Expedited Reviews: Admission & Continuing Stay for Medicaid

MEDICAID ONLY (42 CFR 438.210)

This Level of Care applies to expedited authorization reviews for admission and continuing stay for Level 1 and 2 outpatient services.

Service Description

- For cases in which a network provider (CMHA) indicates that the following the standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, the CMHA MHP must make an expedited authorization request for services, indicating urgent or emergent review status, and provide an authorization request as expeditiously as the individual's health condition requires.
- Crisis services can be provided while the expedited authorization request is pending.

Expedited Admission Criteria

- Individuals with Medicaid coverage, only.
- The standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function
- For admission authorization determination: Must meet Access to Care Standards (ACS) for Admission into Level 1 or 2 services criteria (medical necessity criteria, functional impairment, and diagnosis)
- For continuing stay authorization determination: Must meet continuing stay criteria, as defined by the requested level.
- Requested service is determined medically necessary by MHP

Type of Services/Modalities

- Level 1: Intake assessment, group treatment, brief intervention treatment services, individual and family services, medication management, medication monitoring, psychoeducation, family/ peer supports.
- Level 2: Includes all allowable outpatient services under the state plan. The full scope of outpatient treatment modalities and level of intensity for each modality may be provided based on clinical assessment, medical necessity and individual needs.
    - ➢ EPSDT referred Level 2 services for Medicaid youth can require establishing a formalized Individual Service Team for each child/ youth to further develop a cross system Individual Treatment plan (refer to Child/ Youth LOC for criteria and requirements)

tensity of Service

- Level 1: Brief intervention and low intensity mental health services
- Level 2: Service intensity is individualized, based on *continued* assessment of need and adjustments are reflected in the ISP.

Duration of Episode

- Level 1 Brief: Maximum of 12 individual service hours within 6 months, intended for one time only authorization
- Level 1 Low Intensity: Maximum of 24 individual service hours within 12 months
- Level 2 Long Term Rehabilitation: Minimum of 24 individuals service hours in 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts an intake evaluation by an MHP that establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA telephonically provides or forwards a completed PRAT request with the urgency category flagged to the PRSN ASO. All telephonic information is followed-up with the required documentation.
- ASO immediately reviews the PRAT information, diagnosis information and any additional clinical documentation to support the request, prior to making a service determination, within 3 days from the request.
- ASO provides an authorization determination within 3 working days from the date of request for mental health services. The CMHA may extend the 3 day time period up to 14 calendar days if the individual applying for services requests an extension, or if the provider justifies a need for additional information and how the extension is in the individual's interest.
- Written notification of approved or denied services is provided via mail.

Child and Youth Services
Level 1 & 2 Services
Inactivation & Reactivation of Services

Service Description

- **Clinical inactivation** refers to an individual who has left services within an authorized benefit period. Clinical Inactivations can occur at any point throughout an authorized episode of treatment. *When there has been no direct services provided for authorized episodes over 90 days, the PRSN strongly recommends supervisory review and consideration for administrative closure.*
- **Administrative inactivation** refers to the expiration of an authorized benefit period (6 or 12 months). In rare occurrences, an administrative inactivation is requested when an individual moves out of the catchment area (including enters the prison system) or dies within an authorized benefit period.
- **Reactivation** refers to re-opening a previously clinically inactivated case, within the initial authorized benefit period.

Inactivation Scenarios

- Applies to Medicaid and Non-Medicaid individuals.
- Clinical inactivations may occur when any of the following apply:
  1. The client met their expected treatment goals/outcomes
  2. The client is over the age of 13 years and requests inactivation of treatment
  3. The client is not participating in treatment, has not responded to engagement efforts, and imminent risk issues are not present
  4. The client's whereabouts are unknown, and three attempts to contact them (by two different means) have been unsuccessful
  5. The client's treatment needs can be met through other services available within their support system; care is being/ has been transitioned to another entity
- Administrative inactivations may occur when any of the following apply:
  1. The client does not meet continuing stay criteria and the benefit period expires
  2. The client has moved out of the PRSN
  3. The client is deceased

Reactivation Criteria

- Applies to Medicaid and Non-Medicaid individuals. The request for reactivation is made by a MHP or the primary clinician, under the supervision of a MHP. Non-Medicaid individuals may only be re-activated if there are sufficient resources to support the re-activation service plan.
- Reactivation summary is required to document current information. No additional authorization is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Authorization Protocols

- Inactivations
  - CMHA records the clinical inactivation and documentation summary in the Profiler clinical record.
  - The ASO generates a monthly report to identify individuals with pending administrative inactivations. After 10 days, if the Medicaid individual does not contact the ASO or CMHA requesting on-going services the inactivation is processed/ authorized.
- Reactivations
  - Reactivation documentation is present in the clinical record and re-activation status is entered into Profiler. No additional authorization through the ASO is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Child and Youth Services
Community Hospital Inpatient Services - Voluntary & Involuntary

Service Description

- Inpatient psychiatric services at community hospitals include evaluation, stabilization and treatment and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- The PRSN network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient service requests.
- All voluntary hospitalization requests must be made by a MHP in consultation with, or by a child mental health specialists.

Voluntary Admission Criteria

Voluntary inpatient admissions must meet all of the following baseline criteria (includes Parent-Initiated Voluntary hospitalizations):

1. The existence of a DSM-IV Axis I disorder.
2. Evidence that admission is medically necessary.
3. The child/youth poses an actual or imminent danger to self, others or property due to a mental disorder, **or**
   The child/youth requires brief stabilization and assessment to rule out danger to self and/or others, **or**
   The child/youth is experiencing significant deterioration in age appropriate behavior including family, school, and social functioning **and** an alternative care setting would be unable to provide sufficiently intensive services to diagnose and treat the mental disorder.
4. There is a verified failure of treatment at a lesser level of care, **or**
   A crisis team/ DMHP determines that due to the severity of symptoms, intensity of treatment or lack of supports services cannot be provided at a lesser level of care.
5. Medical evaluation determines that the current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests

When a child/youth ***may exceed*** the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The inpatient facility is responsible for requesting an extension at least 24 hours prior to the expiration date. The inpatient facility must contact the designated network CMHA to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization to CommCare. **The continuing stay/ extension request is case specific and there is no range for authorization.**

- At least one of the following criteria must be present inpatient extension authorization (includes Parent-Initiated voluntary hospitalizations):
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The child/youth continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The child/youth demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The child's/youth's level of functioning has regressed since admit
  5. The child/youth continues to need stabilization to reach baseline functioning and further improvement in condition is expected.

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met **or** unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat **and** the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, a child/youth can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, a child/ youth must meet continued stay criteria to be authorized.
- ***A new certification number must be requested*** and is automatically issued to differentiate between inpatient facilities and legal status changes.

Retro-authorizations

A community hospital may request retro-authorization reviews. For out of state retro-authorization requests, the request must be must be made within three months of discharge.

1. The retro-authorization determination can take up to an additional 30 days.
2. Individual currently admitted to an inpatient facility, CommCare may provide a verbal review and retro-authorization.
3. Individual discharged from inpatient facility, CommCare requires hospital documentation for comprehensive review and determination.

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) for 20 days.
- For voluntary hospitalizations, the standard benefit period for admission and extension requests is determined and requested by the CMHA crisis team (standard range is 1 to 3 days).

Authorization Protocol

- The ASO collects the necessary information for Provider 1 Prior Authorization from Profiler or verbally, identifying the requested inpatient authorization, funding source, and supporting clinical documentation. CommCare will notify DBHR of all Parent-Initiated Voluntary stays.
- ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day.

Child and Youth Services
Youth Inpatient Unit (Network E&T) - Voluntary & Involuntary

Service Description

- Inpatient hospitalization services for children and youth at Kitsap Mental Health Services (KMHS) Youth Inpatient Unit (YIU) include evaluation, stabilization and treatment and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- The PRSN network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient service requests.
- All voluntary hospitalization requests must be made by a MHP in consultation with, or by a child mental health specialists.

Voluntary Admission Criteria- up to a standard 20 day initial authorization. Voluntary inpatient admissions must meet all of the following baseline criteria (includes Parent-Initiated Voluntary hospitalizations):

1. The existence of a DSM-IV Axis I disorder.
2. Evidence that admission is medically necessary.
3. The child/youth poses an actual or imminent danger to self, others or property due to a mental disorder, **or**
   The child/youth requires brief stabilization and assessment to rule out danger to self and/or others, **or**
   The child/youth is experiencing significant deterioration in age appropriate behavior including family, school, and social functioning **and** an alternative care setting would be unable to provide sufficiently intensive services to diagnose and treat the mental disorder.
4. There is a verified failure of treatment at a lesser level of care, **or a** crisis team/ DMHP determines that due to the severity of symptoms, intensity of treatment or lack of supports services cannot be provided at a lesser level of care.
5. Medical evaluation determines that the current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests- up to 10 additional days, per request

When a child/youth ***may exceed*** the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The E&T must contact the network CMHA that initiated the admission to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization. *Each extension request must be reviewed by the PRSN. Upon PRSN review, the request is forwarded from the PRSN to CommCare for authorization.*

- At least one of the following criteria must be present for continuing stay authorization (includes Parent-Initiated Voluntary hospitalizations):
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The child/youth continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The child/youth demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The child's/youth's level of functioning has regressed since admit
  5. The child/youth continues to need stabilization to reach baseline functioning and further improvement in condition is expected.
- Once an individual is admitted to the E&T, the CMHA must contact the E&T to begin coordinating care within one business day.

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met **or** unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat **and** the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, a child/youth can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, a child/ youth must meet continued stay criteria to be authorized
- ***A new certification number must be requested*** and is automatically issued to differentiate between inpatient facilities and legal status changes.

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care.

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) for 20 days.
- For voluntary hospitalizations, the benefit period for admission is up to 20 days. Extension requests (up to 10 days) are requested by the CMHA, reviewed by the PRSN, and authorized by CommCare.
- Continuing stay and extension requests range of days authorized are on a case by case basis.

Authorization Protocol

- Only network CMHA can request authorization for E&T inpatient services, all other parties must facilitate their request through the CMHA.
- The ASO collects the necessary information for an inpatient certification from Profiler or verbally- identifying the requested inpatient authorization. *All extension requests must be submitted to the PRSN for review 3 calendar days prior to the expiration. Upon PRSN review, the request is forwarded to CommCare for authorization.* CommCare will notify DBHR of all Parent-Initiated Voluntary stays.
- The ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day. PRSN conducts 100% review of all NOAs and tracks appeals.

Child and Youth Services
Children's Long Term Inpatient (CLIP) Services

Service Description
CLIP services are a blended residential program that includes therapeutic, medical, and educational modalities for severely emotional disturbed children and youth. CLIP is considered the most restrictive setting. The average length of stay is 6 months. This criteria is for *voluntary* CLIP services.

Routine Admission Criteria
- Applicants must have a severe psychiatric impairment which warrants the intensity and restrictions of the treatment provided in a CLIP Program with verified failure (unable to stabilize) of treatment at a lesser level of care determined medically necessary.
- Per CLIP Administration policy, an individual will be considered to have an impairment if a severe emotional disturbance, corroborated by a clear psychiatric diagnosis, is demonstrated, with one or more of the following behaviors exhibited:
    1. Symptoms explicitly associated with marked, severe and/or chronic thought disorders, as defined in the DSM-IV, such as bizarreness, delusions, hallucinations, disturbed thought processes (e.g., loosened associations, illogical thinking, poverty of content of speech), blunt, flat or inappropriate affect, or grossly disorganized behavior
    2. Symptoms explicitly associated with a marked, severe or chronic affective disorders, as defined in the DSM-IV, including mania, depression, vegetative signs, suicide attempts or self -destructive behaviors.
    3. Chronic or grossly maladaptive behaviors due to a diagnosed severe psychiatric impairment. The presence of such symptoms should be clearly identified as resulting from a mental disorder and not be solely attributable to other factors.
- Medical evaluation determines that the child's/ youth's current medical needs do not exceed the level of care available in the CLIP setting.
- Clear treatment goals and discharge planning recommendations are provided the CLIP program, prior to admission.
- Youth (13 years or older) are willing to agree to voluntary admission and to comply with treatment.
- Youth (13 years and older) whose mental state incapacity or developmental stage does not rule out a "good faith voluntary" admission by virtue of significant cognitive impairment that precludes making a reasoned decision. Determination of "Good Faith Voluntary" may include a review of previous voluntary hospitalizations and the recent pattern of outpatient treatment compliance.
- The local CLIP gatekeeping committee reviews all the material in accordance with these admission criteria, discusses alternative options to CLIP, and provides a determination for CLIP admission.
    1. If the application is approved, it is forwarded to the CLIP Admission for review and approval.
    2. If the application is denied by the community gatekeeping committee, a letter is provided with alternative treatment recommendations outlined.

Continuing Stay Criteria
- Per the CLIP policy, once a child/ youth has been approved for voluntary admission by the CLIP Certification Team and placed on the CLIP Waiting List, the designated child psychiatrist shall review the youth's continued need for admission every 30 days up until the time when they are admitted.

Discharge Considerations
- When the individual meets their treatment goals, no longer meets CLIP criteria for continued stay treatment, and a discharge date is identified:
    1. The CLIP treatment team members, including the community treatment team, shall plan for a smooth transition back to community services.
    2. The CLIP case manager is responsible for coordinating outpatient mental health services and will invite ancillary community-based formal systems to participate in the discharge planning, per established designated working agreements (e.g. DCFS and DDD).
    3. If the child/ youth is planning to move to another RSN, the PRSN CLIP case manager coordinates with the local community mental health agency to liaison and transition care.

Type of Services/Modalities
- Blended residential program that includes therapeutic, medical, and educational modalities for SED children and youth.

Intensity of Service
- 24/7 long-term statewide residential program

Duration of Episode
- Upon admission to a CLIP facility, as determined by CLIP attending psychiatrist. Average LOS is 6 months.

Authorization Protocol
- Voluntary admission authorization occurs through a local gatekeeping panel review, and statewide CLIP Review. No additional authorization is required, upon admission.

Adult Services

Adult Services
Level 1 Outpatient Services

Service Description

- **Brief Intervention** is a solution focused, outcomes oriented cognitive and behavioral intervention intended to resolve situational disturbances that do not require long term treatment. Authorization benefit: 12 service hours within 6 months, *one time only authorization.*
- **Low Intensity Treatment** is provided to provide a person to begin or maintain their recovery progress. Functional problems identified at Intake are included in the ISP, which includes specific steps that demonstrate on-going treatment progress. May include beginning or ongoing care, maintenance or monitoring of current level of functioning, assistance with self care, or life skill training. This level may be used as a step down from a higher, more intense level of care and authorized for multiple episodes. Authorization benefit: 24 service hours for 12 months.

Routine Admission Criteria

- Individuals must meet Access to Care Standards (ACS), and the requested service is determined medically necessary by MHP. ACS include a covered diagnosis, GAF of 60 or lower, and additional criteria if applicable.

EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria may be authorized for Level 2 services (reference Child/ Youth LOC for criteria and requirements):

In addition to the ACS, Non-Medicaid individuals will only be authorized for services if there are sufficient resources and meet ONE of the following criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison and present with an "A" group Axis 1 Diagnosis
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Applied for Medicaid and enrollment decision is pending

Continuing Stay Criteria

- Continuing Stay criteria only apply for continuation of previously authorized services.
- Medicaid individuals can only be re-authorized for Brief Level 1 services **ONCE.**
- Review and documented treatment progress, update ISP, and review/update the crisis prevention plan, as appropriate.
- Requested continued service is determined medically necessary by MHP, and must meet all of the following:
    1. Current ACS covered diagnosis (A or B)
    2. Current symptoms (resulting from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued.
    3. Current symptoms and history demonstrate continued treatment is necessary to maintain gains in functional ability, maintain community safety, or to avoid hospitalization.
    4. Intervention is deemed necessary to improve or stabilize functioning resulting from a covered mental health diagnosis.
    5. The individual is expected to benefit from the intervention.
    6. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).
    7. PRSN adopted Practice Guidelines recommend continued treatment.

In addition to the above, Non-Medicaid individuals will only be authorized for services if there are sufficient resources and meet ONE of the following additional criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison and present with an "A" group Axis 1 Diagnosis.
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization
5. Applied for Medicaid and enrollment decision is pending

Type of Services/Modalities

- Intake assessment, group treatment, brief intervention treatment services, medication management, medication monitoring, and psychoeducation.

Intensity of Service

- Brief intervention and/ or low intensity mental health services

Duration of Episode

- Brief: Maximum of 12 individual service hours within 6 months, intended for one time only authorization
- Low intensity: Maximum of 24 individual service hours for 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists (ethnic minority, disability). CMHA submits a PRAT (identifying requested service level, determination of ACS requirements and medical necessity) to PRSN delegated ASO within 14 days from when the intake was initiated.
- ASO reviews PRAT and supporting documentation and then provides an authorization determination within 14 calendar days from the date of the intake assessment beginning. ASO reviews and authorizes extension requests, when indicated.
- Written notification of authorized services is provided via mail.

Adult Services
Level 2 Outpatient Services

Service Description

- **Long Term Rehabilitation** is necessary to achieve or maintain stability in the community. Intense level of acute outpatient treatment may include active outreach and intensive services to prevent hospitalization, out of home placement, reinforce personal and community safety, and promote the stability and independence of an individual in the community while decreasing the use of other costly services. Authorization benefit: More than 24 service hours in 12 months.

Routine Admission Criteria

- Individuals must meet the Access to Care Standard (ACS), and the requested service is determined medically necessary by MHP. ACS include a covered diagnosis, GAF of 50 or lower, and additional criteria if applicable

EPSDT. Any Medicaid recipient under the age of 21 who meets ANY of the following criteria may be authorized for Level 2 services (reference Child/ Youth LOC for criteria and requirements):

In addition to the ACS, Non-Medicaid individuals will only be authorized if there are sufficient resources and they meet at least ONE of the following criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison and present with an "A" group Axis 1 Diagnosis
4. A Mental Health Professional determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Applied for Medicaid and enrollment decision is pending

- Safety/ Risk Assessment. In addition to the above criteria, one of the following qualifying risk factors must apply for an individual:
  1. Current severity of symptoms makes the individual at risk for hospitalization, if services are not provided at this level
  2. More than 3 contacts with the provider crisis team in the previous month
  3. Psychiatric hospitalization in the previous 3 months
  4. Current suicidal or homicidal ideation, or history of an attempt

Continuing Stay Criteria

- Continuing Stay criteria only apply for continuation of previously authorized level or less intensive level of care.
- Review and document treatment progress, update ISP, and review/update the crisis prevention plan, as appropriate.
- Requested continued service is determined medically necessary by MHP, and must meet all of the following:
  1. Current ACS covered diagnosis (A or B)
  2. Current symptoms (resulting from the covered diagnosis) and history demonstrate a significant likelihood of deterioration if treatment is discontinued.
  3. Current symptoms and history demonstrate continued treatment at this level is necessary to maintain gains to maintain community safety or to avoid hospitalization.
  4. Intervention is deemed necessary to improve or stabilize functioning resulting from a covered mental health diagnosis.
  5. The individual is expected to benefit from the intervention.
  6. Any other formal or informal system or support would not more appropriately meet the individual's unmet need(s).
  7. PRSN adopted Practice Guidelines recommend continued treatment.

In addition to the ACS, Non-Medicaid individuals will only be authorized if there are sufficient resources and they meet at least ONE of the following additional criteria:

1. Have a diagnosis of Schizophrenia, Schizoaffective Disorder, or have psychotic symptoms
2. Present with a risk of Danger to Self or Danger to Others, or have been hospitalized for psychiatric care within the last 6 months
3. Recently released from jail or prison and present with an "A" group Axis 1 Diagnosis
4. A MHP determines that current symptoms and history demonstrate treatment is necessary to avoid hospitalization.
5. Applied for Medicaid and enrollment decision is pending

Type of Services/Modalities

- Includes all allowable outpatient services under the state plan; full scope of outpatient treatment modalities and level of intensity is provided based on clinical assessment, medical necessity and individual needs.

Intensity of Service

- Continuum of high intensity and comprehensive mental health services

Duration of Episode

- Minimum of 24 individuals service hours in 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts intake assessment by an MHP, establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA submits a PRAT (identifying requested service level, determination of ACS requirements and medical necessity) to PRSN delegated ASO within 14 days from when the intake was initiated.
- ASO reviews PRAT and supporting documentation, then provides an authorization determination within 14 calendar days from the date of the intake assessment beginning. ASO reviews and authorizes extension requests, when indicated.
- Written notification of authorized services is provided via mail.

Adult Services
Level 1 & 2 Services
Expedited Reviews: Admission & Continuing Stay for Medicaid

MEDICAID ONLY (42 CFR 438.210)

This Level of Care applies to expedited authorization reviews for admission and continuing stay for Level 1 and 2 outpatient services.

Service Description

- For cases in which a network provider (CMHA) indicates that the following the standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, the CMHA MHP must make an expedited authorization request for services, indicating urgent or emergent review status, and provide an authorization request as expeditiously as the individual's health condition requires.
- Crisis services can be provided while the expedited authorization request is pending.

Expedited Admission Criteria

- Individuals with Medicaid coverage, only.
- The standard timeframe could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function
- For admission authorization determination: Must meet Access to Care Standards (ACS) for Admission into Level 1 or 2 services criteria (medical necessity criteria, functional impairment, and diagnosis)
- For continuing stay authorization determination: Must meet continuing stay criteria, as defined by the requested level.
- Requested service is determined medically necessary by MHP

Type of Services/Modalities

- Level 1: Intake assessment, group treatment, brief intervention treatment services, individual and family services, medication management, medication monitoring, psychoeducation, family/ peer supports.
- Level 2: Includes all allowable outpatient services under the state plan. The full scope of outpatient treatment modalities and level of intensity for each modality may be provided based on clinical assessment, medical necessity and individual needs.
    - ➢ EPSDT referred Level 2 services for Medicaid youth can require establishing a formalized Individual Service Team for each child/ youth to further develop a cross system Individual Treatment plan (refer to Child/ Youth LOC for criteria and requirements)

Intensity of Service

- Level 1: Brief intervention and low intensity mental health services
- Level 2: Service intensity is individualized, based on *continued* assessment of need and adjustments are reflected in the ISP.

Duration of Episode

- Level 1 Brief: Maximum of 12 individual service hours within 6 months, intended for one time only authorization
- Level 1 Low Intensity: Maximum of 24 individual service hours within 12 months
- Level 2 Long Term Rehabilitation: Minimum of 24 individuals service hours in 12 months

Authorization Protocol

- CMHA determines funding eligibility, conducts an intake evaluation by an MHP that establishes medical necessity. Consults with appropriate specialists (child, ethnic minority, disability). CMHA telephonically provides or forwards a completed PRAT request with the urgency category flagged to the PRSN ASO. All telephonic information is followed-up with the required documentation.
- ASO immediately reviews the PRAT information, diagnosis information and any additional clinical documentation to support the request, prior to making a service determination, within 3 days from the request.
- ASO provides an authorization determination within 3 working days from the date of request for mental health services. The CMHA may extend the 3 day time period up to 14 calendar days if the individual applying for services requests an extension, or if the provider justifies a need for additional information and how the extension is in the individual's interest.
- Written notification of approved or denied services is provided via mail.

Adult Services
Level 1 & 2 Services
Inactivation & Reactivation of Services

Service Description

- **Clinical inactivation** refers to an individual who has left services within an authorized benefit period. Clinical inactivations can occur at any point throughout an authorized episode of treatment. *When there has been no direct services provided for authorized episodes over 90 days, the PRSN strongly recommends supervisory review and consideration for administrative closure.*
- **Administrative inactivation** refers to the expiration of an authorized benefit period (6 or 12 months). In rare occurrences, an administrative inactivation is requested when an individual moves out of the catchment area (including enters the prison system) or dies within an authorized benefit period.
- **Reactivation** refers to re-opening a previously clinically inactivated case, within the initial authorized benefit period.

Inactivation Scenarios

- Applies to Medicaid and Non-Medicaid individuals.
- Clinical inactivations may occur when any of the following apply:
  1. The client met their expected treatment goals/outcomes
  2. The client is over the age of 13 years and requests inactivation of treatment
  3. The client is not participating in treatment, has not responded to engagement efforts, and imminent risk issues are not present
  4. The client's whereabouts are unknown, and three attempts to contact them (by two different means) have been unsuccessful
  5. The client's treatment needs can be met through other services available within their support system; care is being/ has been transitioned to another entity
- Administrative inactivations may occur when any of the following apply:
  1. The client does not meet continuing stay criteria and the benefit period expires
  2. The client has moved out of the PRSN
  3. The client is deceased

Reactivation Criteria

- Applies to Medicaid and Non-Medicaid individuals. The request for reactivation is made by a MHP or the primary clinician, under the supervision of a MHP. Non-Medicaid individuals may only be re-activated if there are sufficient resources to support the re-activation service plan.
- Reactivation summary is required to document current information. No additional authorization is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Authorization Protocols

- Inactivations
  - CMHA records the clinical inactivation and discharge summary in the clinical record and Profiler system.
  - The ASO generates a monthly report to identify individuals with pending administrative inactivations. After 10 days, if the Medicaid individual does not contact the ASO or CMHA requesting on-going services the inactivation is processed/ authorized.
- Reactivations
  - Reactivation documentation is present in the clinical record and re-activation status is entered into Profiler. No additional authorization is required (as a case is being re-opened during a previously authorized and within a current benefit period).

Adult Services

Community Hospital Inpatient Services - Voluntary & Involuntary

Service Description

- Community hospitalization services for adults include evaluation, stabilization and treatment services and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- A PRSN network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient service requests.
- All voluntary hospitalizations must be made by a MHP

Voluntary Admission Criteria

Voluntary inpatient admissions must meet all of the following baseline criteria:

1. The existence of a DSM-IV Axis I disorder.
2. Evidence that the admission is medically necessary.
3. The individual poses an actual or imminent danger to self, others or property due to a mental disorder, **or**
   The individual has experienced a marked decline in ability to care for self due to the onset or exacerbation of a psychiatric disorder.
4. There is a verified failure of treatment at a lesser level of care, **or**
   A DMHP determines severity of symptoms, intensity of treatment or lack of supports cannot be provided at a lesser level of care.
5. Medical evaluation determines that the individual's current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests

When an individual **may *exceed*** the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The inpatient facility is responsible for requesting an extension at least 24 hours prior to the expiration date. The inpatient facility must contact the designated network CMHA to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization to CommCare. **The continuing care/ extension request is case specific and there is no range for authorization.**

- At least one of the following criteria must be present for continuing stay authorization:
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The individual continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The individual demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The individual 's level of functioning has regressed since admit
  5. The individual continues to need re-stabilization to reach baseline functioning and further improvement in condition is expected.

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met **or** unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat to the individual, others or property **and** the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, an individual can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, an individual must meet continued stay criteria to be authorized
- ***A new certification number must be requested*** and is automatically issued to differentiate between inpatient facilities and legal status changes.

Retro-authorizations

A community hospital may request retro-authorization reviews. For out of state retro-authorization requests, the request must be made within three months of discharge.

1. The retro-authorization determination can take up to an additional 30 days.
2. Individual currently admitted to inpatient facility, CommCare may provide a verbal review and retro-authorization.
3. Individual discharged from inpatient facility, CommCare requires hospital documentation for comprehensive review and determination

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care.

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) for 20 days.
- For voluntary hospitalizations, the standard benefit period for admission and extension requests is determined and requested by the CMHA crisis team (standard range is 1 to 3 days).

Authorization Protocol

- The ASO collects the necessary information for Provider 1 Prior Authorization from Profiler or verbally, identifying the requested inpatient authorization, funding source, and supporting clinical documentation.
- ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day.

Adult Services

Adult Inpatient Unit (Network E&T) - Voluntary & Involuntary

Service Description

- Inpatient hospitalization for adults at Kitsap Mental Health Services (KMHS) Adult Inpatient Unit (AIU) that include evaluation, stabilization and treatment and can be authorized prior to an intake.
- *All ITA and revocations* to inpatient services are provided a certification number and automatically authorized for 20 days.
- The PRSN network crisis team designated to an individual's geographical area (DMHP) may provide a face to face assessment for inpatient requests.
- All voluntary hospitalizations must be made by a MHP

Voluntary Admission Criteria- up to a standard 20 day initial authorization . Voluntary inpatient admissions must meet all of the following baseline criteria:

1. The existence of a DSM-IV Axis I disorder.
2. Evidence that the admission is medically necessary.
3. The individual poses an actual or imminent danger to self, others or property due to a mental disorder, **or**
   The individual has experienced a marked decline in ability to care for self due to the onset or exacerbation of a psychiatric disorder.
4. There is a verified failure of treatment at a lesser level of care, **or**
   A DMHP determines severity of symptoms, intensity of treatment or lack of supports cannot be provided at a lesser level of care.
5. Medical evaluation determines that the individual's current medical needs do not exceed the level of care available in the inpatient setting.

Voluntary Continuing Stay Criteria & Extension Requests

When an individual may ***exceed*** the initial authorization expiration date, a request for continuing stay is required prior to the expiration date. The E&T must contact the network CMHA that initiated the admission to request the extension. Only the network CMHA can make a request for a continuing stay voluntary hospitalization to CommCare. **The continuing care/ extension request is case specific and there is no range of days for authorization.**

- At least one of the following criteria must be present for continuing stay authorization:
  1. The full assessment has not been completed and cannot be completed at a lesser level of care
  2. The individual continues to pose actual or imminent danger to self, others, or property that cannot be contained at a lesser level of care
  3. The individual demonstrates an inability to function or is gravely disabled and continues to require on-going inpatient care.
  4. The individual 's level of functioning has regressed since admit
  5. The individual continues to need re-stabilization to reach baseline functioning and further improvement in condition is expected.
- Once an individual is admitted to the E&T, the CMHA must contact the E&T to begin coordinating care within one business day. .

Discharge Considerations

- Discharge happens as soon as a less-restrictive plan for treatment can be safely implemented.
- Reasonable efforts must be made to meet all of the following:
  1. Inpatient treatment plan objectives have been substantially met **or** unmet objectives can be resolved at a lesser level of care.
  2. Unresolved treatment plan objectives are addressed in a discharge plan and an appropriate outpatient program is identified.
  3. Discharge to a less intensive level of care does not pose a threat to the individual, others or property **and** the treating physician authorizes the discharge.
  4. For AMA discharges, contact information for local crisis line and community mental health agency is provided.

Inpatient Facility Transfers and Legal Status Changes

- With changes within an authorized episode, an individual can be transferred from one inpatient facility to another without meeting new admission criteria. With transfers occurring with expiring authorization, an individual must meet continued stay criteria to be authorized for 20 days
- ***A new certification number must be requested*** and is automatically issued to differentiate between inpatient facilities and legal status changes.

Type of Services/Modalities

May include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.

Intensity of Service

24/7 acute psychiatric inpatient care.

Duration of Episode

- For ITA or if LRA is revoked, the authorization is automatically approved (admission and continuing stay) and LOS is determined by court order.
- For voluntary hospitalizations, the benefit period is up to 20 days for admission and extension requests are requested by the CMHA/ determinations are made by the ASO.

Authorization Protocol

- Only the network CMHA can request authorization for inpatient E&T services, all other parties must facilitate their request through CMHA.
- The ASO collects the necessary information for an inpatient certification from Profiler or verbally, identifying the requested inpatient authorization, funding source, and supporting clinical documentation. All extension requests must be submitted to the PRSN for review 3 calendar days prior to the expiration. Upon PRSN review, the request is forwarded to CommCare for authorization.
- The ASO verifies voluntary criteria sufficiently met through supporting documentation, and provides the authorization determination within 12 hours of request. If criteria and medical necessity for voluntary admission is not sufficiently met, CommCare may authorize administrative days.
- With an inpatient service denial, the ASO provides a Peer Review and service denial notification within 1 business day. PRSN conducts 100% review of all NOAs and tracks appeals.

Adult Services

Residential Services: Brief & Long Term Intensive

Service Description

Residential services are services provided to assist individuals living in community-based settings, like Keller House and Arlene Engel House. Residential services differ from other services in terms of location and duration. Residential services can be brief or long-term:

Brief Residential Service is defined as residing 28 days or less at a facility.

Long Term Intensive Service is defined as residing 180 days or less (within 6 months) at a residential facility.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage. ***Non-Medicaid individuals will only be authorized within available resources.***
- Must meet Access to Care Standards (ACS) or admission to outpatient services (medical necessity criteria, functional impairment, and diagnosis)
- Must be requested service by MHP and deemed medically necessary. An individual must demonstrate one of the following to be admitted:
  1. The presenting signs of a psychiatric illness clearly demonstrate a need for residential level structure, supervision and treatment that cannot be stabilized at a lesser level of care.
  2. The individual has a history or recent episode of failing to live independently in the community due to his/her psychiatric illness.
- In addition to the above criteria, all the following must apply:
  1. The individual is an adult age 18 years or older.
  2. The individual is ambulatory and does not require physical or chemical restraints.
  3. The individual has adequate cognitive functioning to enable him/her to respond to fire alarms and evacuate the premises without emergency assistance.
  4. The individual is currently enrolled in outpatient services and has a current Crisis Plan, or is in the process of being authorized and assigned to outpatient services.

Exclusion Criteria

If an individual demonstrates any of the following, they are excluded from residential services: However, the exclusion can be waived based on the individual's level of functioning.

1. *The individual has a psychiatric condition that qualifies for a higher level of care.*
2. *The individual is actively suicidal and/or homicidal, per MHP staff assessment.*
3. *The individual has a recent history of a pattern of assault/violent behaviors toward self or others.*
4. *The individual has a physical condition requiring medical or nursing care available only in a hospital or other more intensive nursing environment. Cases requiring limited medical or nursing care will be evaluated on an individual basis by PRSN Registered Nursing (RN) staff.*
5. *The individual is in need of detoxification.*
6. *The individual has a history of being a sexual predator or* of committing arson.

Continuing Stay Criteria

At least one of the following criteria must be met:

1. Admission criteria for residential services continues to be met.
2. The individual must have a treatment plan that identifies need and measurable goals for residential services. The individual must be making progress toward treatment goals.
3. For supported living homes, the consumer may choose to stay for an extended period while enrolled in an outpatient episode of care.

Discharge Considerations

- One of the following must be met for discharge from residential services:
  1. The individual's residential treatment goals have been sufficiently met.
  2. The individual no longer meets admission or continuing stay criteria for residential services, **or** meets criteria for a less/more intense LOC.
  3. There is an appropriate discharge plan to a less restrictive level of care that identifies components for maintaining treatment gains.
  4. Consent for treatment is withdrawn, and it is determined that the individual does not meet the criteria for residential treatment.
- If the individual is non-compliant in treatment or in following the residential program rules and regulations, despite treatment attempts to address non-compliance issues, they may be discharged to a more/less intensive level of care.

Type of Services/Modalities

- Residential program that includes therapeutic, medical, and assisted living for individuals.

Authorization Protocol

- The PRSN residential authorization requirements will not conflict with or overrule Boarding Home licensing requirements. Evictions will be in compliance with Boarding Home WAC 388-78A-2660 (Residents Rights) and applicable Landlord/Tenant laws.
- CMHA determines funding eligibility, establishes medical necessity, and identifies placement.
- CMHA submits a PARS form (identifying requested residential service level, documenting criteria requirements and medical necessity) to PRSN delegated ASO.
- ASO reviews PARS and supporting documentation prior to authorization determination. ASO provides an authorization determination within 14 calendar days from the date of request for services.
- With a service denial, the ASO mails written notification to the individual.

Adult & Child/Youth Services

Crisis & Stabilization

Respite

Adult & Child/Youth Services
Crisis & Stabilization

Service Description

- A **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. Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate intervention.
- **Stabilization services** are to be provided in the person's own home, or another home-like setting, or a setting that provides safety for the individual and the mental health professional. Stabilization services may include ancillary crisis services to cover costs for room and board.
- PRSN network CMHAs mental health crisis response teams are authorized to coordinate stabilization services. The CMHAs may coordinate crisis stabilization services outside their designated areas, and within the network, in order to ensure access and availability.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage.
- For stabilization services to be provided, all of the following baseline criteria must be met:
  1. The individual is in crisis, as defined above.
  2. The stabilization services will prevent further deterioration.
  3. The stabilization services are located in the best-suited and least restrictive environment.
  4. The stabilization services are medically necessary, as determined by a MHP.
  5. The individual does not meet criteria for a more intensive level of care.
  6. The individual agrees to participate in the voluntary stabilization service(s).
  7. A description of the stabilization services that are to be provided with an estimate length of the service(s) duration, up to 14 days per episode, is documented in the crisis/ clinical chart.

Admission Exclusion Criteria

- Stabilization services are not provided if any of the following apply:
  1. The individual is in need of medical stabilization for physical/organic dysfunctions beyond the scope and resources of the stabilization service(s).
  2. The individual is assessed to be in need of an inpatient facility.
  3. The individual is in need of drug/alcohol detoxification.
  4. When an individual exceeds the initial authorization amount and a request for continuing stay is made, at least one of the following criteria must be met.

Continuing Stay Criteria

- All of the following must apply:
  1. Admission criteria for this level continues to be met.
  2. A description of explaining the continued need for the stabilization service(s) with an estimated length of the service(s) duration documented in the crisis/clinical chart.
- When an individual exceeds the initial planned amount (up to 14 days), continuing stay is required to continue to provide the stabilization services.

Discharge Considerations

- Any of the following may lead to a discharge of stabilization service(s):
  1. The individual no longer meets admission criteria.
  2. The individual requires a less/more restrictive level of care.
  3. There is a reasonable plan for follow-up services, in or outside the network, identified. .
- The individual requests discharge/ termination of stabilization service(s). If a child, the caregiver requests discharge/ termination of stabilization service(s).

Type of Services/Modalities

- Stabilization services include short-term (up to 14 days, per episode) face-to-face assistance with life skills training and/ or understanding of medication effects.

Authorization Protocol

- Stabilization services are considered a crisis service modality available to all residents of the PRSN.
- Crisis stabilization services do not require authorization from the PRSN **and** can be provided prior to an intake assessment.
- The CMHA MHP determines when stabilization services are medically necessary for initial and continuing stay.
- Initial authorization can not exceed14 days and continuing stay cannot exceed 14 days, per episode. Only one episode can be authorized at a time.

Adult & Child/Youth Services
Respite

Service Description

- **Respite Care** services are used to sustain the primary caregivers of children and youth with emotional disorders or adults with mental illness. Respite care is provided in a manner that provides necessary relief to caregivers. Respite services include providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of a individuals by someone other than the primary caregivers. Respite services are provided by, or under the supervision of, a mental health professional.

  Respite services may be provided in a variety of settings, such as the caregiver's home, in an organization's facilities, or in the respite worker's home. The care should be flexible to ensure that the individual's daily routine is maintained. Respite services may be provided on a planned or an emergent basis and are voluntary.

- Only PRSN network CMHAs are authorized to provide respite services. All other interested parties must facilitate their requests through the CMHAs.

Routine Admission Criteria

- Individuals with Medicaid and Non-Medicaid coverage.
- For respite care service(s) to be provided, all of the following standard criteria must be met:
  1. The individual must be currently authorized for PRSN funded outpatient care, the expedited admission review process can be used
  2. The respite care services are medically necessary.
  3. The individual does not meet criteria for a more intensive level of care.
  4. The individual agrees to participate in the voluntary respite care service(s).
  5. A description of the respite care service(s) that are provided with an estimate length of the service(s) duration is documented in the clinical chart.
- In addition to the required criteria listed above, at least one of the following must apply:
  1. The individual's caregiver has no other respite options available at the time of the needed service.
  2. The individual faces a potential crisis such as a housing emergency, significant loss, etc. and without respite support would be at significant risk for decompensation and potential hospitalization.
  3. The consumer is in need of continuous support and supervision during a medication titration.

Admission Exclusion Criteria

- Respite care services are not provided if any of the following apply:
  1. The individual is in need of medical stabilization for physical/organic dysfunctions beyond the scope and resources of the respite service.
  2. The individual is assessed to be in need of an inpatient facility
  3. The individual is in need of drug/alcohol detoxification.

Continuing Stay Criteria

- All of the following must apply:
  1. Admission criteria for this level of care must continue to be met.
  2. The individual must have a treatment plan that identifies need and measurable goals for respite care services. The individual 's progress toward treatment goals is based on the effectiveness of the respite services to the overall treatment plan.

Discharge Considerations

- Any of the following may lead to a discharge of respite service(s):
  1. The individual no longer meets respite admission criteria, or outpatient authorization expired and does not meet criteria for continued outpatient services.
  2. The individual requires a less/more restrictive level of care.
  3. The plan for the respite service was successfully completed.
  4. There is a reasonable plan for follow-up services in place.
  5. The individual requests discharge/ termination of respite service(s). If a child, the caregiver requests discharge/ termination of respite service(s).

Type of Services/Modalities

- Respite services include providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of a consumer by someone other than the primary caregivers.

Authorization Protocol

- Respite services are authorized with outpatient services, no additional authorization is required.
- A Respite benefit period is the same as the authorized outpatient services benefit period.
- Reference LOC for Outpatient Services.

PENINSULA REGIONAL SUPPORT NETWORK
Utilization Management Plan
FY 2015-2016

The Peninsula Regional Support Network (PRSN) Utilization Management (UM) Plan summarizes the processes, procedures, standards and monitoring mechanisms that govern the utilization management program. The PRSN UM functions attempt to strike a balance between promoting a recovery based service delivery system and effectively managing resources.

The PRSN UM Plan is designed to comply with the contractual requirements outlined in the Agreement with the Washington State Department of Social and Health Services.

PRSN Mission

The Peninsula Regional Support Network (PRSN) is dedicated to ensuring and continually improving the delivery of quality mental health care so that the individuals we serve may better manage their illness, achieve their personal goals, and live, work and participate in their community.

The PRSN is committed to creating and supporting a mental health treatment system that focuses on supporting consumers and encouraging recovery and resiliency. We understand and promote the understanding that mental health is an essential element of overall health and mental illnesses are conditions from which people can and do recover.

The PRSN UM program strives to assist every individual in receiving quality care through utilization of adequate resources in the most cost effective manner. The PRSN believes a managed care structure allows for the delivery of the highest possible quality care, in a coordinated and cost effective manner.

Introduction

The PRSN provides a full range of mental health services to individuals within the service delivery geographical area, providing the required covered services for the Medicaid and state only revenue contracts. The PRSN provides comprehensive and medically necessary services in a variety of settings including, but not limited to outpatient, inpatient, residential, and intensive outpatient programs. The PRSN delivers timely, appropriate, and quality mental health services through an effective and carefully monitored network of mental health providers. All services requested, authorized, and provided for individuals using PRSN funding are subject to utilization review.

- *State funded services are provided according to the state defined priority services and additional outpatient services are provided based upon available resources.*

Service Delivery Structure: The PRSN has an extensive and fully licensed network of mental health providers that delivers comprehensive, quality care. The PRSN sub-capitates the Medicaid service funding with the core network providers, thereby ensuring full participation in implementing cost effective utilization management strategies.

Standard Authorization Structure: The PRSN has contracted with Community Network for Behavioral Healthcare, Inc. (CommCare) to authorize PRSN services requests from the provider network. CommCare is accredited by the Utilization Review Accreditation Commission (URAC) and is required to maintain the accreditation per contract. CommCare is responsible for providing service authorization determinations for services the PRSN has identified as requiring prior authorization, on behalf of the PRSN, for Medicaid and non-Medicaid individuals seeking mental health services.

PRSN Oversight Committee: The PRSN operates a UM committee to provide network oversight of the UM Plan activities, identify UM program and plan improvements, and review the Plan at least annually. The PRSN UM committee is responsible for prioritizing the UM Plan activities, targeting areas needing improvement, identifying benchmarks, and maintaining threshold capacity. The UM Committee members are listed in attachment 1.

Utilization Program Goals

The goal of the PRSN UM program is to provide a process that systematically monitors and evaluates service delivery to ensure individuals have access and are receiving timely and appropriate mental health services to meet their needs. In addition, the UM activities provide a continuous framework for network evaluation of the appropriate use and amount of current resources within the network. The process focuses on monitoring contract requirements and developing cost-effective strategies within the service delivery structure.

Utilization Management Program Objectives

The PRSN UM program strives to ensure easy and timely access to appropriate treatment; work collaboratively with each network provider in delivering quality care; address the needs of special populations; and make appropriate clinical decisions at the level closest to the individual. The UM program attempts to integrate with the network providers UM activities and internal quality management strategies where possible. The PRSN UM program emphasizes the principles of recovery, reintegration, rehabilitation, and resiliency which include involvement of individuals, and their families, in the direction their treatment.

Utilization Management Program Structure

The UM program operates in a clearly defined organizational structure (see attachment 1). The PRSN UM program is supported by adequate clinical staff from multiple levels within the service structure, including staff from CommCare, the PRSN staff, and the network provider's senior management and clinical staff. The PRSN Quality Improvement Committee (QUIC) is responsible for the overarching oversight of the UM program, prioritizing monitoring activities and reviewing UM committee functions.

CommCare, the PRSN utilization management contractor, is required to adhere to Utilization Review Accreditation Commission (URAC) standards. CommCare is contracted to review authorization requests for outpatient, inpatient, and residential care.

CommCare's utilization management system improves the functioning and quality of life of individual served by the PRSN by applying a clinically sound, consumer-oriented, and cost-effective authorization process to the regional system of care.

CommCare's Care Managers are behavioral health clinicians who are trained to address not only the psychological needs of the individual and their families, but also their medical and social needs. Each member of the clinical staff averages over four (4) years of experience in the case management of Medicaid populations. The CommCare Medical Director is a board- certified psychiatrist who oversees all of CommCare's clinical activities. (see attachment 2 verify if accurate)

The PRSN Resource Development Manager, Adult Clinical Review Manager, Quality Assurance Manager, and Childrens Mental Health Services Manager participate in the PRSN UM program. The PRSN Resource Development Manager is responsible for this plan and activities monitoring for network sufficiency, facilitates the monthly UM meetings, and maintains the PRSN Level of Care criteria. The Clinical Review Manager conducts clinical chart reviews, monitors internal network adherence to authorized care, and facilitates the network Clinical Directors meetings. The PRSN Quality Assurance Manager is responsible for providing the linkages between the UM Plan to the PRSN Quality Management (QA) Plan, including plan activities and committees. The PRSN Childrens Mental Health Services Manager is responsible for oversight of the continuum of care for Childrens services.

The Utilization Management Committee (UMC) reports to the QUIC that is compiled of PRSN staff, network provider senior clinical management staff, advisory board members and clients/ client advocates. The network agency representative have been oriented and trained on PRSN clinical criteria, case management philosophy and procedures, and treatment resources available. Each network agency provide at least one representative that routinely attends the quarterly face to face meetings. The QUIC meetings are quarterly face to face meetings.

The UMC is responsible for:

- Monitoring of the service authorization process; ensuring access to care meets standards.
- Establish, and on-going review of the PRSN criteria for each level of care.
- Monitoring of authorization movement through and across levels of care (including authorization of intensity levels of care, such as inpatient treatment).
- Monitoring the process of re-authorizing or extended service outpatient authorization.
- Tracking inpatient service denials (including the process of appeal).
- Monitoring inpatient utilization trends.
- Established regional benchmarks and thresholds of authorization procedures.
- Evaluating current network sufficiency and recommending changes to the governing boards and other PRSN committees, as necessary.
- Recommends Corrective Action Plans for concerning trends, such as late PRAT requests.
- Assists in the development of UM Policies and Procedures (including Levels of Care criteria), and annually reviews UM Plan.
- Reviews and makes recommendations for updates to the authorization forms (PRAT for outpatient services, PARS for residential services, certification/authorization for inpatient services, and other relevant authorization documents).
- Operationalizes state-directed inpatient authorization requirements/ modifications, such as the Community Psychiatric Instructions and parent Initiated Treatment.

The PRSN ensures that utilization management activities are not structured in such a way as to provide incentives to any individual or entity to deny, limit, or discontinue medically necessary mental health services to any enrollee as evidenced in the PRSN policy: Authorization of Services: Independence from Financial Incentives.

Service Authorization for Routine Care, Medicaid and non-Medicaid

The PRSN utilization management contractor, CommCare, uses the medical necessity criteria, Levels of Care standards, and *resources available* when making authorization determinations. The PRSN requires prior authorization for all routine outpatient service levels. These standards are reviewed at least annually (through chart reviews and data reports) to incorporate the evidence based and best practice industry standards in the behavioral health field.

The PRSN adopts Levels of Care Standards that:

a. Include the Department's Access to Care Standards.
b. Promote individual progress towards the highest possible level of health and self sufficiency.
c. Can be reasonably expected to benefit the individual's mental health.
d. Are medically necessary and appropriate to the individual's condition.
e. Are designed to assist individuals in managing their illness to the greatest extent possible in order to live, learn, and work in their own communities.
f. For non-Medicaid services, are provided based upon available resources

Service Authorization Principles

1. The service authorization process is intended to meet all applicable requirements of the Centers for Medicare and Medicaid Services (CMS) and the Washington State Department of Social and Human Services, Division of Behavioral Health and Rehabilitation.

2. The service authorization process is designed to allow for rapid approval, with a minimum of steps to promote timely access to services. All service authorizations provide an expedited review process for urgent and emergent situations, as well as a standard review process.

    - Corrective Action plans will be required for late PRATs, exceeding 15% of the monthly total.

3. Medicaid recipients/enrollees will be authorized and receive all medically necessary mental health services defined in the Medicaid state plan.

4. Individuals not enrolled in Medicaid will be authorized and receive medically necessary outpatient mental health services subject to availability of resources.

5. All individuals residing within the PRSN have access to state funded crisis services.

6. Family member involvement is valued by the PRSN. Families will be encouraged to be involved in the assessment, service planning and treatment process whenever possible. Family non-involvement will not result in denial of service.

7. Authorized services will be provided in the most clinically effective, cost effective and least restrictive setting.

Outpatient Service Authorization Process

1. Following the Intake Assessment, service admission authorization requests typically are made by the PRSN network provider mental health professional that conducted the intake assessment. Requests are made using the Peninsula Regional Assessment Tool (PRAT) and submitted electronically to CommCare via Profiler. Profiler is the regional Electronic Medical Record (EMR).

2. The admission PRAT for outpatient services requires the following information:
    - Medicaid recipient/enrollee or Non-Medicaid assigned funding.
    - Multi-axial diagnosis, including if there is a covered A or B diagnosis and the required additional criteria for B diagnosis.
    - Access to Care standards, including medical necessity criteria questions and GAF/CGAS score information.
    - Requested Level of Care.
    - For Level 2 services, additional risk assessment criteria.
    - For admission authorization beyond 14 days from the intake assessment, a request for an extension is required.
    - (optional) If entrance criteria is not met, referral provided.
    - (optional) There is a text box that allows for additional information to be provided by the requestor.

4. The PRSN network provider submits a PRAT (for outpatient episode of care authorization) requesting service authorization to CommCare via Profiler. CommCare may review additional documentation, such as the Intake Assessment and other relevant information available in the electronic medical record in making an authorization determination according to the PRSN standards.

5. CommCare will make an authorization determination; document the determination on the PRAT and transmits an on-line authorization determination back to the network provider.
    - The PRSN directly notifies individuals in writing when outpatient services are authorized. The PRSN Handbook accompanies the notification letter.
    - When requested services are denied authorization, CommCare mails a letter of determination to the individual.
    - For inpatient requests, CommCare mails a letter of determination to the facility.

6. If the requested service is denied, individuals are found to not qualify for outpatient services, or there are not sufficient resources to provide services- CommCare will issue a service denial notification, on behalf of the PRSN, to the Medicaid and non-Medicaid individual.
    - The notification letter is mailed directly to the individual and a copy is mailed to the PRSN office.
    - CommCare will conduct the Notice of Action Appeals for authorization decisions and service denials they issue for Medicaid individuals. Reference PRSN policy: Notice of Action Requirements.

7. The PRSN staff conduct retrospective reviews of a sample of authorized charts, as a part of the quality management plan and annual chart reviews of network contractors and subcontractors.

    The individual service plan (ISP) is reviewed as a part of the retrospective reviews to ensure it:
    - Meets the needs of the individual.
    - Is consistent with the requested LOC and adopted PRSN Clinical Practice guidelines.
    - Includes consumer participation in the treatment planning process.
    - Involved family members, when appropriate, in the evaluation and service planning processes.
    - Includes input from other formal service systems and is consistent with privacy requirements.

8. The PRSN staff conduct targeted chart reviews in cases in which a concern or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been a concerning adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.

9. If a network provider performs below expected standards during any of the reviews, listed above, a Corrective Action will be required for PRSN approval.

<u>Authorization for Inpatient Services, Medicaid and Non-Medicaid</u>

The PRSN utilization management contractor, CommCare, uses the Department of Social and Health Services statewide Community Psychiatric Inpatient Instructions Per Diem (implemented August 1, 2007), medical necessity criteria and PRSN Levels of Care standards when making inpatient authorization determinations. The PRSN requires prior authorization for all inpatient services. The PRSN provides an expedited review process for urgent and emergent inpatient authorizations.

Involuntary placements into an acute psychiatric hospital or evaluation and treatment center must be automatically authorized and in accordance with the notification process outlined in the, DSHS Community Hospital Billing Instructions (section F).

All service denials of requested inpatient care are made by CommCare's board certified psychiatrist or consulting physician.

A. Service Authorization Process for Inpatient

The PRSN inpatient authorization process follows the Community Hospital Billing Instructions.

1. The request for inpatient services is verbally requested and followed-up with an electronically submitted request to CommCare to authorize. CommCare is required to use the medical necessity and PRSN Levels of Care for authorization determination.

2. CommCare is required to provide an authorization determination (certification) to the requesting entity. This may be an initial verbal determination; followed by confirmation entered into Profiler and/ or Provider 1 database.

   CommCare provides written certification to the facility or individual. For voluntary retro reviews, CommCare will provide written certification to the facility and individual.

3. A PRSN Crisis Response Team conducts a crisis face to face evaluation within 2 hours of a request and determine the level of acuity. For out of region requests, the request is verbally assessed by CommCare within 2 hours of the request.

4. The PRSN Crisis Response Team submits the request for inpatient services, providing the necessary documentation, to make an inpatient authorization determination. The determination to authorize inpatient care shall be completed within 12 (twelve) hours from the initial request for authorization. The determination is entered into Provider 1 by the next business day for community inpatient facilities and Profiler. Determinations for requests at the local Evaluation and Treatment Centers are entered into Profiler by the next business day.

5. The PRSN staff conducts retrospective reviews of a sample of inpatient authorized charts, as a part of the quality management plan, annual E&T administrative reviews, and chart reviews of network contractors and subcontractors.

6. The PRSN staff conducts targeted chart reviews in cases in which a concern or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.

7. If a network provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

8. The inpatient facility is responsible for requesting extension/continuing stay requests and retro-certifications, 24 (twenty-four) hours prior to the expiration of an episode.
   - CommCare makes authorization determinations for extension, continuing stay requests and retro-certifications

B. Discharge Planning for voluntary hospitalizations

The PRSN expects the network provider to coordinate the discharge planning for individuals voluntarily hospitalized

The discharge planning process must begin within 3 days of admission and include:

- Purposeful use of the individual's/family's strengths
- Identification of what caused the individual to need hospital or out of home placement
- What the individual and his/her family need to be successful in the community
- Identified solutions to getting those needs met
- Offered Outpatient appointment (within 7 days of inpatient discharge)

A follow-up outpatient appointment must be offered within 7 (seven) days of discharge. These discharge coordination dates are tracked using monthly UM reports.

An individual, and their family, must be an integral part of the treatment and discharge planning, with a voice in the discharge placement decisions. Discharge planning is integral to the authorization, retrospective certifications, and re-authorization process.

Authorization for Intensive Residential Services (adults), Medicaid and Non-Medicaid

The PRSN utilization management contractor, CommCare, uses the medical necessity criteria and Levels of Care standards developed and adopted by the PRSN when making intensive residential service authorization determinations. The PRSN requires prior authorization for intensive brief and long-term residential service for adults. *Authorization of residential services for non-Medicaid individuals will be based upon available resources.*

A. Service Authorization Process for Intensive Residential Services

1. The PRSN network provider submits an electronic Peninsula Assessment for Residential Services (PARS) request (for intensive residential services authorization) service authorization to CommCare via Profiler. CommCare may review additional documentation, such as the Intake Assessment, Crisis Prevention Plan, Individual Service Plan (ISP) and other relevant information in making an authorization determination according to the PRSN standards.

2. CommCare will make an authorization determination; document the determination on the PARS form and transmits an on-line authorization determination back to the network provider. The network provider is responsible for providing and verbally notifying individuals of their authorized residential services.

3. If the requested service is denied, CommCare will issue a service denial notification, on behalf of the PRSN, to the Medicaid and Non-Medicaid individual.

4. The PRSN staff conduct retrospective reviews of a sample of charts authorized for residential services, as a part of the quality management plan and annual Residential Reviews of network contractors and subcontractors.

5. The PRSN staff conduct targeted chart reviews in cases in which a concern or grievance regarding the authorization determination is raised, when a network provider staff requests a review, when there has been an adverse incident or potential for negative media occurs, or when determined necessary due to repeated and uncorrected errors identified in retrospective reviews.

6. If a network provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.

Continuing Stay and Service Re-Authorization

The PRSN network providers use the Levels of Care (LOC) developed and adopted by the PRSN when making re-authorization determinations.

- The PRSN requires prior re-authorization for *all* continuing stay inpatient services.
- The PRSN requires re-authorization for outpatient service episodes when a previously authorized benefit period expires.
- The PRSN does not require a re-authorization within a current authorized benefit period. The PRSN network providers may close and re-open a clinical episode within an authorized administrative benefit period.

The PRSN LOC for outpatient and inpatient care outline the re-authorization criteria must be met, documentation provided to support criteria, and information reviewed when re-authorizing a service episode.

Service re-authorizations for Non-Medicaid individuals must meet the LOC additional requirements to serve the individuals. *There must be available resources to provide the services.*

The PRSN may request a review of the individual service plan (ISP) as part of the continuing stay service authorization process to ensure it:

- Meets the needs of the individual.
- Is consistent with the requested LOC and adopted PRSN Clinical Practice guidelines.
- Includes consumer participation in the treatment planning process.
- Involved family members, when appropriate, in the evaluation and service planning processes.
- Includes input from other formal service systems and is consistent with privacy requirements.

Consistency of Authorization Determination and Service Requests

The PRSN has formally adopted the *Authorization of Outpatient Services Based on Medical Necessity* policy and Levels of Care protocol to ensure the PRSN, network providers, and CommCare share a common definition and standardized process to determine the medical necessity of requested and authorized mental health services provided by the PRSN.

The PRSN expects the utilization management contractor, CommCare, to consistently apply and authorize the most appropriate Level of Care and service modalities, based upon the request and clinical documentation provided for determining medical necessity.

The PRSN expects the network providers to provide clear and consistent assessments, request clinically appropriate services, and adhere and deliver services within the scope of authorized mental health services.

Limitations on the Provision of Covered Services, Medicaid and Non-Medicaid

The PRSN contracts with CommCare to make all the service authorization decisions on behalf of the PRSN.

A. There are several ways that CommCare can limit the provision of Medicaid covered services. These include:
   - Determining that an enrollee does not meet Access to Care standards.
   - Denying authorization for a requested covered service: Denials of a requested service will be addressed through the PRSN service denial and notification policy and procedures.
   - Determining to reduce, suspend or terminate a previously authorized service.
   - Pend an authorization request, awaiting additional information

B. There are several ways that CommCare can limit the provision of services to Non-Medicaid individuals. These include all the above, a reduction of resources, as well as the additional criteria for Non-Medicaid individuals.

C. When one of the above actions occurs, CommCare through the notification process informs an individual in writing. Medicaid recipients receive a Notice of Action for all actions and Non-Medicaid individuals receive a PRSN Letter of Ineligibility.

   When services are reduced as a result of reduced state funding, a notification letter is mailed to the individual with a copy sent to the PRSN.
   - CommCare will conduct the NOA appeal, if requested.
   - PRSN will conduct a Grievance investigation, if requested.
   - DSHS will conduct a Fair Hearing, if requested.

Ensuring Client Rights Are Provided

The PRSN places a high priority on informing individuals seeking services of their rights. The PRSN ensures individuals are provided this information through the DSHS booklet, the PRSN Handbook and brochures, and reviews the provision of information through monthly on-site chart reviews, and annual Administrative Reviews. A clinical chart must evidence that individuals were given the client rights information prior to the completion of the intake assessment. The PRSN developed and distributes the informational PRSN Handbook and brochures, and a standardized outpatient client rights form to network providers to be given to each individual seeking services. The PRSN also distributes the informational material to subcontractors, such as the local Ombuds office, BRIDGES to Parent Voice program, and NAMI advocacy groups.

Individuals with sensory impairments, or who speak a language other than English, are provided equal access to this information through:

- Provision of material in Braille.
- Use of a DSHS TDD language or TTY line.
- Access to certified sign and language interpreters.
- PRSN contracted hearing impaired consultant.
- Client rights are posted in common areas of the network agencies in the seven DSHS identified languages.

Clients are informed that mental health professional and primary mental health care providers, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of them with respect to their mental health status. Reference the PRSN policies: General Information and Requirements, Enrollee Rights, and Mental Health Care Professional Advocacy policies.

Clients are informed of their second opinion rights, how and when to request a second opinion, and payment of costs associated with providing a second opinion in the published and distributed documents, as well as on the Notice of Action and PRSN Letter of Ineligibility.

PRSN Oversight and Sampling Methodology

The PRSN utilizes random sampling to select charts for clinical and targeted reviews. The PRSN conducts a minimum of 500 chart reviews annually, sufficient to meet CMS and the Department requirements for reviews. Additional reviews may occur to address performance issues, concerning trends, or to accomplish utilization management or quality management activities.

The PRSN conducts annual Administrative Reviews of each network provider, the ASO, and the local Ombuds office. During the network provider administrative reviews, the PRSN may randomly identify 10% of the direct service staff to interview face to face.

- The interview questions include purpose of the local Ombuds office, three client right questions (one specifically about outpatient second opinion rights), advocating for clients authorization of services, and procedures for access a certified interpreter to ensure the integrity of the network system. If there is an area of interview questions that are vague or consistently answered incorrectly, the PRSN requests a corrective action plan typically related to training/supervision.

Over and Under Utilization Project

The PRSN monitors and detects for consistent application of requested, authorized, and provided services through an over and under utilization project that meets federal requirements. Both of these projects are monitored through regional quality assurance activities. Both projects are explained in the PRSN Quality Management Plan.

High Utilizers: The PRSN monitors for high inpatient utilization through chart reviews, with a targeted data pull and with specific items on the crisis chart review tool.

Under Utilizers: The PRSN monitors for outpatient under utilization through a data report and/or chart reviews.

Examination of Network Sufficiency

The PRSN UM program uses a variety of measures as indicators of network sufficiency and resources sufficiency. These indicators include:

- Historical use of resources.
- Current use of resources.
- Projections for future use and need of resources.
- Funding shifts- expenses and revenue reports.
- Quarterly Provider Performance Reports
- Census information for Medicaid and general population growth, by age, ethnicity, and gender.
- Monitoring of outpatient and inpatient utilization through the Authorization and Utilization Management Reports reviewed monthly by the UMC.

The PRSN has polices and procedures for collecting the service data, demographic, and census data, as evidenced in the Using the Information System for Utilization and Resource Management policy.

Integration of Utilization Management Data

Utilization management data is an integral part of the PRSN overall quality improvement strategy. The PRSN UM Plan defines areas of focus, establishes thresholds and benchmarks against which performance is measured, and defines special utilization management studies to be conducted.

The PRSN utilizes a regional and statewide database system to collect the required service data for individuals receiving PRSN funded services:

- Client Demographic Information.
- Social Security Number.
- Health Insurance Information (plan, group number, subscriber name).
- Attending Physician/Practitioner Information/Primary Mental Health Care Provider assigned.
- Client Diagnosis/Treatment Information.
- Inpatient/Residential Facility Information.

Unique situations may require for additional information prior to making an authorization determination. Clinical and demographic information may be shared within the PRSN service network to avoid multiple requests for information from patients and providers.

Information from utilization management activities is aggregated, trended and analyzed to establish validity for completeness, accuracy, and timeliness. The PRSN staff and UMC evaluate the data using comparative statistical methods to identify variance from expected

performance and reviews progress over time for trends or patterns. They report their findings to the PRSN QUIC.

The PRSN staff, UMC, and QUIC monitor performance against the benchmarks established in the Quality Management Plan. Should required activities not result in attainment of established benchmarks, the QUIC can impose corrective actions or implement concurrent reviews, as required to achieve benchmarks.

When analysis of available data suggests a deficiency in the sufficiency of the network, the UMC and/or the QUIC presents the issue for discussion and decision making to the PRSN governing boards.

Annual Evaluation of the PRSN UM Program

The PRSN Utilization Management Program is reviewed, evaluated and revised annually. The plan evaluation includes an assessment of the UM plan activities, and the extent to which compliance was achieved with the specified performance standards and outcomes.

The plan evaluation includes:

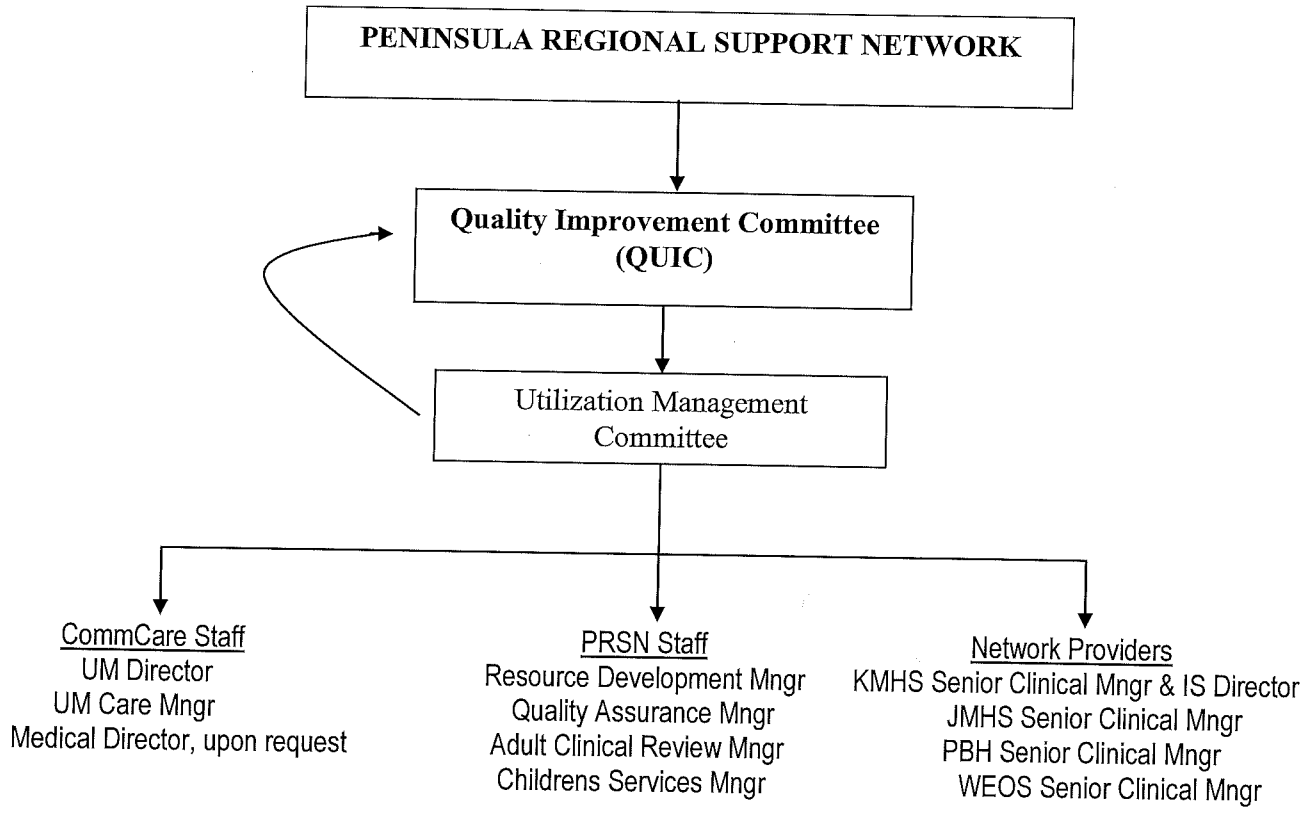
1. Identification of activities to be included in the subsequent year's Utilization Management Program.
2. Identification of any barriers to implementing the Utilization Management Program.
3. Recommended changes in the PRSN infrastructure, as needed, to accomplish the goals of the UM Plan.
4. Identification of opportunities for improvement through the provision of on-site technical assistance or training.
5. Updating information within the UM Plan that accurately reflect the monitoring and oversight activities.
6. Recommended changes or additions to the criteria for monitoring over or under utilization project.

The written summary of the evaluation is prepared by the PRSN staff, in conjunction with UM Committee, and presented to the QUIC.

The annual UM Program evaluation is the basis for the development and focus of the upcoming fiscal year's established priorities.

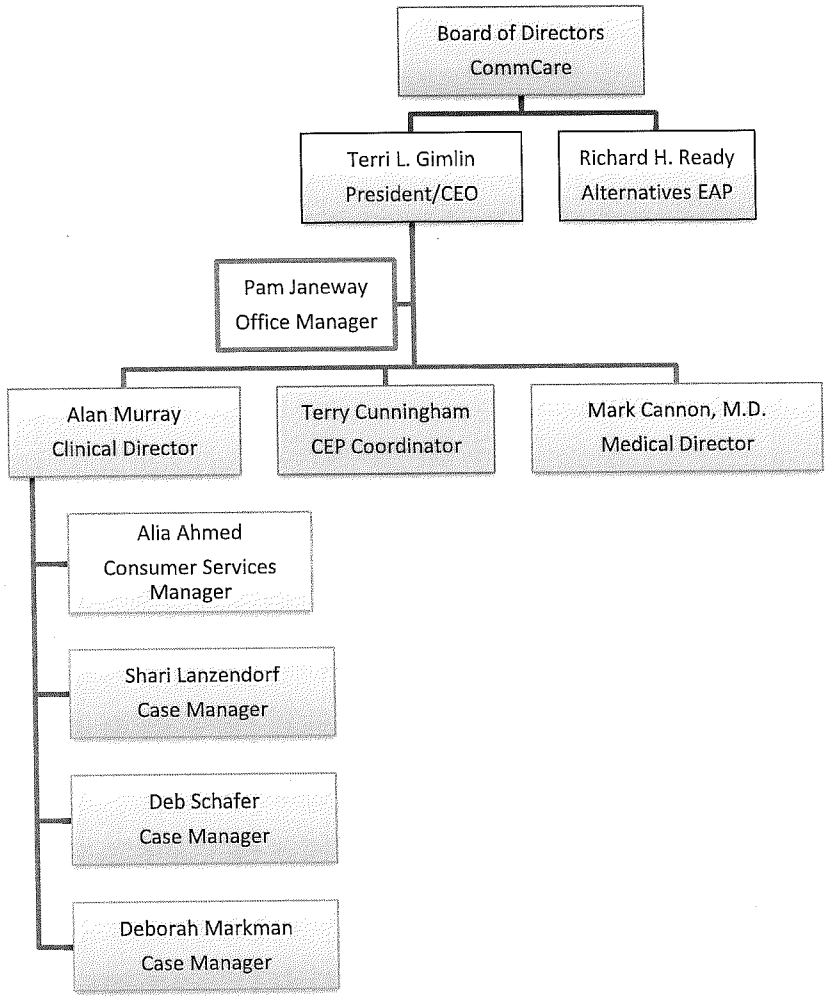
Attachment 1

PRSN
Utilization Management & Clinical Directors Committee
Organizational Chart



Attachment 2

PENINSULA REGIONAL SUPPORT NETWORK
Contracted Authorization and Utilization Management
CommCare Organizational Chart



Credentials for CommCare Staff

Alia Ahmed, LSCSW	Shari Lanzendorf, LCSW
Deb Schafer, LCSW	Deborah Markman, RN

INTERLOCAL AGREEMENT BETWEEN KITSAP COUNTY as the Administrative entity for the PENINSULA REGIONAL SUPPORT NETWORK AND QUILEUTE TRIBE FOR MENTAL HEALTH SERVICES KC-318-14

This Interlocal Agreement between Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK and the Quileute Tribe (this "Agreement") is entered into by Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK (the "PRSN"), a political subdivision of the State of Washington, and the Quileute Tribe (the "Tribe"), a federally recognized Indian tribe, effective January 1, 2015.

RECITALS

WHEREAS, Kitsap County is the administrative entity for the Peninsula Regional Support Network;

WHEREAS, Kitsap County, on behalf of the Peninsula Regional Support Network, has entered into an "RSN Agreement" with the State of Washington Department of Social and Health Services (the "State"), Division of Behavioral Health and Recovery, under which the State provides funds to the County for the provision of services to mentally ill residents of Kitsap, Jefferson and Clallam Counties;

WHEREAS, the County wishes to subcontract with the Tribe to enable the Tribe to provide enhanced mental health services to Quileute tribal members and other non tribal members seeking services from the Tribal clinic;

WHEREAS, the Tribe is willing to comply with all applicable contractual and program requirements contained in the State-County Grant Contracts;

WHEREAS, the Tribe, being a sovereign government, has requested that the subcontract be in the form of an interlocal agreement and the State has encouraged the County to subcontract in that form, and

WHEREAS, the State has reviewed the form of this Agreement and found that it satisfies the County's subcontracting obligations under the State-County Grant Contracts.

AGREEMENT

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Statement of Work. The Tribe agrees to provide services in accordance with Exhibit A – Statement of Work.

2. Funding. The services to be performed will be funded by payment by the County to the Tribe as described in the attached Statement of Work, in an amount not to exceed $24,966. This Agreement is expressly contingent throughout its term upon funding availability.

3. State-County Grant Contracts. The State-County Grant Contracts, as they may be amended from time to time, are incorporated by this reference as if set forth fully herein and this Agreement shall be subject to the provisions contained in the State-County Grant Contracts. The Tribe agrees to comply with all provisions contained in the State-County Grant Contracts applicable to subcontractors, except for those provisions, if any, that the State may expressly waive in writing, or is not applicable under federal or state law.

4. Culturally Relevant Services. In providing services, the Tribe may develop and operate programs and deliver goods, services and/or benefits in a manner that is culturally relevant and particularly suited to and/or particularly located for access by members of the Tribe, in accordance with tribal laws and policies.

5. Term. The term of this Agreement is January 1, 2015 – December 31, 2016.

6. Termination for Convenience. Either party may terminate this Agreement for convenience by providing the other party with advance written notice of at least 30 days.

7. Termination for Default. If either defaults in its obligations under this Agreement, the nondefaulting party may terminate this Agreement by written notice to the defaulting party. Before such termination, however, the defaulting party shall be given 10 days to cure its default, if the default is of a type reasonably susceptible to cure.

8. Dispute Panel. The parties may voluntarily submit any contractual dispute to a dispute panel as follows: each party will appoint one member to the panel and those two members in turn will appoint a third member. The dispute panel will review the facts, contract provisions and applicable law, and then decide the matter. This provision does not affect the right of either party to seek legal recourse in a court of competent jurisdiction.

9. Indemnification. Each party agrees to defend and indemnify the other party and its officials, officers, employees and agents for all claims, liabilities, damages, expenses and suits arising from or relating to the performance of this Agreement by the indemnitor or its officials, officers, employees and agents.

10. Commercial General Liability. The Tribe shall have Commercial General Liability Insurance with limits of not less than Combined Bodily Injury/Property Damage Liability of $1,000,000 each occurrence and $2,000,000 aggregate. The Tribe will place insurance with insures licensed to do business in the State of Washington and having A.M. Best Company ratings of no less that A-VII, with the exception that excess and umbrella coverage used to meet the requirements for limits of liability or gaps in coverage need not be placed with insurers or re-insurers licensed in the State of Washington.

Coverage shall contain general requirements and endorsements with Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County named as an additional insured and that in the event of a claim or suit, the insurance carrier agrees to not use sovereign immunity of the assured as defense as respects this agreement. Such insurance as carried by the Tribe is primary over any insurance carried by the Peninsula Regional Support Network and Kitsap County, Jefferson County, Clallam County. The Tribe will include all subcontractors as insureds under its policies or will furnish separate certificates and endorsements for each subcontractor. All coverage for subcontractors will be subject to all the requirements in these provisions.

The Tribe expressly agrees to a limited waiver of sovereign immunity as a defense up to the limits of the insurance policy in connection with the enforcement of the rights of the Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County.

11. Audit Requirements. All payments under this agreement are subject to audit. The Tribe shall provide an independent audit which:

a. Determines the fiscal integrity of the financial transactions and reports of the Tribe.
b. Is performed by an independent auditing firm or the Washington State Auditor's Office.
c. Is performed in accordance with generally accepted auditing standards and with Federal Standards for Audit of Governmental Organizations, Programs, Activities and Functions, and meeting all requirements of OMB Circular A-133, as applicable for agencies receiving federal funding in the amount of $500,000 or more during their fiscal year.

12. Suspension, Debarment, and Lobbying
The Contractor shall certify, on a separate form (Exhibit D), that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency. Also, the Contractor, on a separate form (Exhibit E), will certify that it does not use Federal funds for lobbying purposes. Both forms are attached to this Contract.

13. Notices. Any notice required or permitted under this Agreement shall be given in writing and addressed as follows:

To the PENINSULA REGIONAL SUPPORT NETWORK
Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366
Attention:
Anders Edgerton, Regional Administrator

To the TRIBE
Quileute Health Clinic
P.O. Box 189
LaPush, WA 98350-0279
Attention:
Sandra Lyons, Accounting Manager

Either party may change its address for notices by providing written notice to the other party.

14. Independent Capacity. The officials, officers, employees and agents of each party shall continue to be officials, officers, employees and agents of that party and shall not be considered for any purpose to be officials, officers, employees and agents of the other party.

15. Waiver. Waiver of any part of this Agreement may only be made in a writing executed by an authorized representative of the party to be bound.

16. Applicable Law. Each party shall comply with all applicable federal, tribal, state and local law.

17. Amendment. This Agreement may be amended only by a writing executed by authorized representatives of both parties with the same formalities as this Agreement.

18. Survival. Sections 8 (Dispute Panel), and 9 (Indemnification) of this Agreement shall survive the termination or expiration of this Agreement.

19. Authority. Each party warrants that it has taken all steps necessary for this Agreement to have full legal effect and that the signatures hereon are those of its authorized representatives.

20. Exhibits. The following exhibits are incorporated in this Agreement by reference:

Exhibit A: Statement of Work
Exhibit B: Budget Summary
Exhibit C: Certificate of Liability Insurance and Sovereignty Endorsement
Exhibit D: Certification Regarding Debarment, Suspension, and Other Responsibility Matters
Exhibit E: Certification Regarding Lobbying

IN WITNESS WHEREOF, THE PARTIES HAVE SUBSCRIBED THEIR NAMES HERETO ON THE DATES SET FORTH BELOW.

PENINSULA REGIONAL SUPPPORT NETWORK, By the Kitsap County Board of Commissioners, It Administrative Entity

ROBERT GELDER, Chair

EDWARD E. WOLFE, Commissioner

CHARLOTTE GARRIDO, Commissioner

ATTEST:

Dana Daniels, Clerk of the Board

DATED: 3-9-15

QUILEUTE TRIBE

Chas Woodruff, Tribal Chairperson

DATED: 2/19/15

BOARD OF COMMISSIONERS STATE OF WASHINGTON KITSAP COUNTY

EXHIBIT A: STATEMENT OF WORK

YEAR 1 Planned Activity	Expected Accomplishment	Timeframe for Activity	Cost
GOAL 1: Continue to provide an on-going Diabetes Support Group and develop alternative services for the Quileute and other Native People seen at the Quileute Health Center. Include access to a limited number of tribal employees if appropriate.	Provide emotional and educational support for individuals striving to manage a difficult and sometimes frightening disease. The Support Group may include incentives and a diabetes-friendly breakfast as part of the group structure. • Approximately 20 individuals served.	January 1, 2015 through December 31, 2015	
GOAL 2: Develop mental health self-help Resource Library for the Quileute and other Native People that benefit from services available at the Quileute Health Center.	Purchase books, videos, equipment, and related material for a Tribal Resource Library. Items would be available for check-out. • Approximately 30-40 individuals served.	January 1, 2015 through December 31, 2015	
GOAL 3: Continue ongoing Support Group that combines features that you might find in an ACOA or Al-Anon group in an urban setting.	Provide emotional and educational support for adults who: (a) grew up in a home with significant drug/alcohol issues; or (b) are currently dealing with a family member or significant other who has drug/alcohol issues. The support group may include incentives, educational material, announcements, and/or possible training-related expenses for the group facilitators.	January 1, 2015 through December 31, 2015	
TOTAL EXPENSES FOR 2015 INTER-LOCAL AGREEMENT PROJECT PLAN:			**$12,483**

YEAR 2 Planned Activity	Expected Accomplishment	Timeframe for Activity	Cost
GOAL 1: Continue to provide an on-going Diabetes Support Group and develop alternative services for the Quileute and other Native People seen at the Quileute Health Center. Include access to a limited number of tribal employees if appropriate.	Provide emotional and educational support for individuals striving to manage a difficult and sometimes frightening disease. The Support Group may include incentives and a diabetes-friendly breakfast as part of the group structure. • Approximately 20 individuals served.	January 1, 2016 through December 31, 2016	
GOAL 2: Develop mental health self-help Resource Library for the Quileute and other Native People that benefit from services available at the Quileute Health Center.	Purchase books, videos, equipment, and related material for a Tribal Resource Library. Items would be available for check-out. • Approximately 30-40 individuals served.	January 1, 2016 through December 31, 2016	
GOAL 3: Continue ongoing Support Group that combines features that you might find in an ACOA or Al-Anon group in an urban setting.	Provide emotional and educational support for adults who: (a) grew up in a home with significant drug/alcohol issues; or (b) are currently dealing with a family member or significant other who has drug/alcohol issues. The support group may include incentives, educational material, announcements, and/or possible training-related expenses for the group facilitators.	January 1, 2016 through December 31, 2016	
TOTAL EXPENSES FOR 2016 INTER-LOCAL AGREEMENT PROJECT PLAN:			**$12,483**
GRAND TOTAL			**$24,966**

EXHIBIT B: BUDGET SUMMARY

Quileute Tribe Enhanced Mental Health Services

Expenditure Cost Category	Budget Period	Previous Budget	Changes this Contract	Current Budget
Year 1 State Funded Match Mental Health Services – Contract Services	1/1/15 – 12/31/15	0		$12,483
Year 2 State Funded Match Mental Health Services – Contract Services	1/1/16 – 12/31/16	0		$12,483
Total				$24,966

EXHIBIT C: CERITIFICATE OF INSURANCE

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/26/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Denise Sweazey
Brown & Brown of Washington, Inc. 1501 Fourth Ave Suite 2400 Seattle WA 98101	PHONE (A/C, No, Ext): 206-956-1652 FAX (A/C, No): 206-956-9652 E-MAIL ADDRESS: dsweazey@bnbseattle.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A: HUDSON INSURANCE COMPANY — 25054
INSURED: QUILE-1 Quileute Tribal Council PO BOX 279 La Push WA 98350	INSURER B:
	INSURER C:
	INSURER D:
	INSURER E:
	INSURER F:

COVERAGES **CERTIFICATE NUMBER:** 1167812223 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY	Y		NACL00238-09	7/1/2014	7/1/2015	EACH OCCURRENCE	$2,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$250,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$Excluded
							PERSONAL & ADV INJURY	$Included
							GENERAL AGGREGATE	$10,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$4,000,000
	POLICY PRO-JECT LOC							$
A	AUTOMOBILE LIABILITY	Y		NACL00238-09	7/1/2014	7/1/2015	COMBINED SINGLE LIMIT (Ea accident)	$2,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
							Comp/Coll	$500
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N/A						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Medical Malpractice Liability			NACL00238-09	7/1/2014	7/1/2015	Annual Aggr. Each Claim	1,000,000 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

RE: Quileute Interlocal Agreement
Peninsula Regional Support Network, Kitsap County, Jefferson County, and Clallam County are named as additional insured in regards to the above project by written contract and/or agreement with the named insured.

RECEIVED
JUL 01 2014
DEPT. OF HUMAN SERVICES

CERTIFICATE HOLDER

Peninsula Regional Support Network
614 Division Street
MS-23
Port Orchard WA 98366

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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EXHIBIT D: CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

Primary Covered Transactions 45 CFR 76

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principles:

   a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

   b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connections with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;

   c. Are not presently indicted for or otherwise criminally or civilly charges by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph 1.b. of this certification; and

   d. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the prospective primary participants are unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

This Certification is executed by the person(s) signing below who warrant they have authority to execute this Certification.

CONTRACTOR: QuileuteTribe

Name: Chris Woodruff

Title: Chairman

DATE: 2/19/15

EXHIBIT E: CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and believe, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Quileute Tribe

Contractor Organization

Chelsea Woodruff 2/19/15

Signature of Certifying Official Date

INTERLOCAL AGREEMENT BETWEEN
KITSAP COUNTY as the Administrative entity for the PENINSULA REGIONAL SUPPORT NETWORK
AND
HOH TRIBE
FOR
MENTAL HEALTH SERVICES
KC-313-14

This Interlocal Agreement between Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK and the Hoh Tribe (this "Agreement") is entered into by Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK (the "PRSN"), a political subdivision of the State of Washington, and the Hoh Tribe (the "Tribe"), a federally recognized Indian tribe, effective January 1, 2015.

RECITALS

WHEREAS, Kitsap County is the administrative entity for the Peninsula Regional Support Network;

WHEREAS, Kitsap County, on behalf of the Peninsula Regional Support Network, has entered into an "RSN Agreement" with the State of Washington Department of Social and Health Services (the "State"), Division of Behavioral Health and Recovery, under which the State provides funds to the County for the provision of services to mentally ill residents of Kitsap, Jefferson and Clallam Counties;

WHEREAS, the County wishes to subcontract with the Tribe to enable the Tribe to provide enhanced mental health services to Hoh tribal members and other non tribal members seeking services from the Tribal clinic;

WHEREAS, the Tribe is willing to comply with all applicable contractual and program requirements contained in the State-County Grant Contracts;

WHEREAS, the Tribe, being a sovereign government, has requested that the subcontract be in the form of an interlocal agreement and the State has encouraged the County to subcontract in that form, and

WHEREAS, the State has reviewed the form of this Agreement and found that it satisfies the County's subcontracting obligations under the State-County Grant Contracts.

AGREEMENT

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Statement of Work. The Tribe agrees to provide services in accordance with Exhibit A – Statement of Work.

2. Funding. The services to be performed will be funded by payment by the County to the Tribe as described in the attached Statement of Work, in an amount not to exceed $24,966. This Agreement is expressly contingent throughout its term upon funding availability.

3. State-County Grant Contracts. The State-County Grant Contracts, as they may be amended from time to time, are incorporated by this reference as if set forth fully herein and this Agreement shall be subject to the provisions contained in the State-County Grant Contracts. The Tribe agrees to comply with all provisions contained in the State-County Grant Contracts applicable to subcontractors, except for those provisions, if any, that the State may expressly waive in writing, or is not applicable under federal or state law.

4. Culturally Relevant Services. In providing services, the Tribe may develop and operate programs and deliver goods, services and/or benefits in a manner that is culturally relevant and particularly suited to and/or particularly located for access by members of the Tribe, in accordance with tribal laws and policies.

5. Term. The term of this Agreement is January 1, 2015 - December 31, 2016.

6. Termination for Convenience. Either party may terminate this Agreement for convenience by providing the other party with advance written notice of at least 30 days.

7. Termination for Default. If either defaults in its obligations under this Agreement, the nondefaulting party may terminate this Agreement by written notice to the defaulting party. Before such termination, however, the defaulting party shall be given 10 days to cure its default, if the default is of a type reasonably susceptible to cure.

8. Dispute Panel. The parties may voluntarily submit any contractual dispute to a dispute panel as follows: each party will appoint one member to the panel and those two members in turn will appoint a third member. The dispute panel will review the facts, contract provisions and applicable law, and then decide the matter. This provision does not affect the right of either party to seek legal recourse in a court of competent jurisdiction.

9. Indemnification. Each party agrees to defend and indemnify the other party and its officials, officers, employees and agents for all claims, liabilities, damages, expenses and suits arising from or relating to the performance of this Agreement by the indemnitor or its officials, officers, employees and agents.

10. Commercial General Liability. The Tribe shall have Commercial General Liability Insurance with limits of not less than Combined Bodily Injury/Property Damage Liability of $1,000,000 each occurrence and $2,000,000 aggregate. The Tribe will place insurance with insures licensed to do business in the State of Washington and having A.M. Best Company ratings of no less that A-VII, with the exception that excess and umbrella coverage used to meet the requirements for limits of liability or gaps in coverage need not be placed with insurers or re-insurers licensed in the State of Washington.

Coverage shall contain general requirements and endorsements with Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County named as an additional insured and that in the event of a claim or suit, the insurance carrier agrees to not use sovereign immunity of the assured as defense as respects this agreement. Such insurance as carried by the Tribe is primary over any insurance carried by the Peninsula Regional Support Network and Kitsap County, Jefferson County, Clallam County. The Tribe will include all subcontractors as insureds under its policies or will furnish separate certificates and endorsements for each subcontractor. All coverage for subcontractors will be subject to all the requirements in these provisions.

The Tribe expressly agrees to a limited waiver of sovereign immunity as a defense up to the limits of the insurance policy in connection with the enforcement of the rights of the Peninsula Regional Support Network and Kitsap County, Jefferson County, and Clallam County.

11. Audit Requirements. All payments under this agreement are subject to audit. The Tribe shall provide an independent audit which:

a. Determines the fiscal integrity of the financial transactions and reports of the Tribe.
b. Is performed by an independent auditing firm or the Washington State Auditor's Office.
c. Is performed in accordance with generally accepted auditing standards and with Federal Standards for Audit of Governmental Organizations, Programs, Activities and Functions, and meeting all requirements of OMB Circular A-133, as applicable for agencies receiving federal funding in the amount of $500,000 or more during their fiscal year.

12. Suspension, Debarment, and Lobbying
The Contractor shall certify, on a separate form (Exhibit D), that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency. Also, the Contractor, on a separate form (Exhibit E), will certify that it does not use Federal funds for lobbying purposes. Both forms are attached to this Contract.

13. Notices. Any notice required or permitted under this Agreement shall be given in writing and addressed as follows:

To the PENINSULA REGIONAL SUPPORT NETWORK
Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366
Attention:
Anders Edgerton, Regional Administrator

To the TRIBE
Hoh Tribe
P.O. Box 809
Forks, WA 98331
Attention:
Annette Penn, Director, ICW

Either party may change its address for notices by providing written notice to the other party.

14. Independent Capacity. The officials, officers, employees and agents of each party shall continue to be officials, officers, employees and agents of that party and shall not be considered for any purpose to be officials, officers, employees and agents of the other party.

15. Waiver. Waiver of any part of this Agreement may only be made in a writing executed by an authorized representative of the party to be bound.

16. Applicable Law. Each party shall comply with all applicable federal, tribal, state and local law.

17. Amendment. This Agreement may be amended only by a writing executed by authorized representatives of both parties with the same formalities as this Agreement.

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19. Authority. Each party warrants that it has taken all steps necessary for this Agreement to have full legal effect and that the signatures hereon are those of its authorized representatives.

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Exhibit A: Statement of Work
Exhibit B: Budget Summary
Exhibit C: Certificate of Liability Insurance and Sovereignty Endorsement
Exhibit D: Certification Regarding Debarment, suspension, and Other Responsibility Matters
Exhibit E: Certification Regarding Lobbying

IN WITNESS WHEREOF, THE PARTIES HAVE SUBSCRIBED THEIR NAMES HERETO ON THE DATES SET FORTH BELOW.

PENINSULA REGIONAL SUPPPORT NETWORK, By the Kitsap County Board of Commissioners, It Administrative Entity

ROBERT GELDER, Chair

EDWARD E. WOLFE, Commissioner

CHARLOTTE GARRIDO, Commissioner

ATTEST:

Dana Daniels, Clerk of the Board

DATED: Jun 12, 15

HOH TRIBE

Maria Lopez, Tribal Council Chair

DATED: 12/12/14

BOARD OF COMMISSIONERS STATE OF WASHINGTON KITSAP COUNTY

EXHIBIT A: STATEMENT OF WORK

(updated 12/5/14)

Planned Activity	Expected Accomplishment	Timeframe for Activity	Cost
Year 1			
Provide mental health individual counseling for adults and an additional mental health group counseling session. Includes culturally appropriate food and supplies for groups and individual services.	Groups that provides specific and detailed mental health topics/ discussions for up to 20 clients (includes health and wellness group, Tribal Youth program, diabetes group and Domestic Violence groups).	January 1, 2015 – December 31, 2015	
Provide mental health group counseling for adults.	Group discussions regarding different mental health topics for 15 clients.	January 1, 2015 – December 31, 2015	
Year 2			
Provide mental health individual counseling for adults and an additional mental health group counseling session. Includes culturally appropriate food and supplies for groups and individual services.	Group that provides specific and detailed mental health topics/ discussions for up to 20 clients (includes health and wellness group, Tribal Youth program, diabetes group and Domestic Violence groups).	January 1, 2016 – December 31, 2016	
Provide mental health group counseling for adults.	Group discussions regarding different mental health topics for 15 clients.	January 1, 2016 – December 31, 2016	
		Total	$24,966

EXHIBIT B: BUDGET SUMMARY

KC-313-14

Hoh Tribe Enhanced Mental Health Services

Expenditure Cost Category	Budget Period	Previous Budget	Changes this Contract	Current Budget
Year 1 State Funded Match Mental Health Services – Contract Services	1/1/15 – 12/31/15	0		$12,483
Year 2 State Funded Match Mental Health Services – Contract Services	1/1/16 – 12/31/16	0		$12,483
Total				$24,966

EXHIBIT C: CERITIFICATE OF INSURANCE

ACORD

HOHIN-2 OP ID: IM

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/01/14

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER THE MAHONEY GROUP - MESA 1835 South Extension Road Mesa, AZ 85210-6942 Bob L. Matson Phone: 480-730-4920 Fax: 480-730-4929	CONTACT NAME: Mindy Sharp PHONE (A/C, No, Ext): 480-214-2771 FAX (A/C, No): E-MAIL ADDRESS: msharp@mahoneygrop.com
INSURED Hoh Indian Tribe P.O. Box 2196 Forks, WA 98331	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: Hudson Insurance Company — 25054 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY X CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC	X		NACL0043406	07/01/14	07/01/15	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG SIR	$ 5,000,000 $ 250,000 $ $ 5,000,000 $ 7,000,000 $ 7,000,000 $ 1,000
A	AUTOMOBILE LIABILITY ☐ ANY AUTO X ALL OWNED AUTOS ☐ SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS	X		NACL0043406	07/01/14	07/01/15	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 2,000,000 $ $ $
	☐ UMBRELLA LIAB ☐ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N ☐ If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		OBH152683688	10/01/13	10/01/14	WC STATU-TORY LIMITS X OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

*Complete Certificate Holder: Peninsula Regional Support Network and Kitsap County, Jefferson County and Clallam County.
*Does not include coverage for Medical Malpractice.

CERTIFICATE HOLDER

Peninsula Regional Support Network *
614 Division St., HS-23
Port Orchard, WA 98366

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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EXHIBIT D: CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

Primary Covered Transactions 45 CFR 76

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principles:

   a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

   b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connections with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;

   c. Are not presently indicted for or otherwise criminally or civilly charges by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph 1.b. of this certification; and

   d. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the prospective primary participants are unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

This Certification is executed by the person(s) signing below who warrant they have authority to execute this Certification.

CONTRACTOR: Hoh Tribe

Name: Maria S. Lopez

Title: Tribal Chair

DATE: 12/12/14

EXHIBIT E: CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and believe, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Hoh Tribe

12/12/14

Contractor Organization Date

Signature of Certifying Official

CFDA#: N/A

INTERLOCAL AGREEMENT BETWEEN KITSAP COUNTY as the Administrative entity for the PENINSULA REGIONAL SUPPORT NETWORK AND PORT GAMBLE S'KLALLAM TRIBE FOR MENTAL HEALTH SERVICES KC-314-14

This Interlocal Agreement between Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK and the Port Gamble S'Klallam Tribe (this "Agreement") is entered into by Kitsap County as the Administrative Entity for the PENINSULA REGIONAL SUPPORT NETWORK (the "PRSN"), a political subdivision of the State of Washington, and the Port Gamble S'Klallam Tribe (the "Tribe"), a federally recognized Indian tribe, effective January 1, 2015.

RECITALS

WHEREAS, Kitsap County is the administrative entity for the Peninsula Regional Support Network;

WHEREAS, Kitsap County, on behalf of the Peninsula Regional Support Network, has entered into an "RSN Agreement" with the State of Washington Department of Social and Health Services (the "State"), Division of Behavioral Health and Recovery, under which the State provides funds to the County for the provision of services to mentally ill residents of Kitsap, Jefferson and Clallam Counties;

WHEREAS, the County wishes to subcontract with the Tribe to enable the Tribe to provide enhanced mental health services to Port Gamble S'Klallam tribal members and other non tribal members seeking services from the Tribal clinic;

WHEREAS, the Tribe is willing to comply with all applicable contractual and program requirements contained in the State-County Grant Contracts;

WHEREAS, the Tribe, being a sovereign government, has requested that the subcontract be in the form of an interlocal agreement and the State has encouraged the County to subcontract in that form; and

WHEREAS, the State has reviewed the form of this Agreement and found that it satisfies the County's subcontracting obligations under the State-County Grant Contracts.