Clinical Policy: Behavioral Health Wraparound Support

Reference Number: WA.CP.BH.521
Last Review Date: 03/25
Effective Date: 05/01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The purpose of this policy is to provide guidelines for approving behavioral health wraparound support (BHWS) services. BHWS is a program that provides support to members/enrollees whose needs are solely related to behaviors attributed to a psychiatric diagnosis and meet established criteria. The members/enrollees must have authorization from Home and Community Services (HCS), a Washington state agency responsible for coordinating long term care services for persons with disabilities and the elderly.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that wraparound support services may be **approved** when *all* the following conditions (A, B, C and D) are met:

A. The member/enrollee has a primary diagnosis of a serious mental illness (schizophrenia, bi-polar disorder, major depressive disorder)
   1. Primary diagnoses of intellectual disabilities, Alzheimer's/dementia, traumatic brain injury or substance use disorder are excluded as serious mental illness diagnoses. However, consideration will be made for these primary diagnoses when a co-occurring serious mental illness diagnosis is present.

B. The member/enrollee has needs that are solely related to behaviors attributed to the psychiatric diagnosis; the behaviors and symptoms cause impairment and functional limitations in self-care/self-management activities requiring additional support.

C. The member/enrollee meets one of the following:
   1. Member/Enrollee is in an in-home setting or
   2. Member/Enrollee is currently approved for supports and needs ongoing payment approval until their next CARE assessment and the determination of 1915(i) state plan eligibility.

D. The member/enrollee meets one of the following:
   1. The member/enrollee is currently receiving mental health services or
   2. There is a plan to engage the member/enrollee in needed mental health services or
   3. The member/enrollee's needs are met by Residential services Waiver (RSW) services through HCA (e.g., ECS, SBS, ESF, other).

Operational Considerations

I. The following information is from the IMC Wraparound contract:

A. Coordinated Care will abide by the following funding request process:
   1. HCS or its designee will use the CARE tool to determine personal care needs.
   2. HCS will send a funding request to Coordinated Care at the initial assessment and annually thereafter if the Member/Enrollee appears to meet criteria and needs

additional behavioral health supports to be served in the community. HCS will provide both of the following:
   a. BHWS Request for MCO Funding form (DSHS 13-712).
   b. A copy of the CARE assessment including a service summary.

B. To support completion of an accurate assessment, Coordinated Care will provide the following information when it is missing from the request:
   1. Information to connect HCS or its designee with the member/enrollee's outpatient behavioral health providers.
   2. Historical information relating to emergency department visits, inpatient stays, medications, and/or medical and behavioral health providers.

C. Coordinated Care shall provide HCS Headquarters with updates to internal contacts for funding requests, care coordination escalation, and the billing form within five business days of a change or when requested.

D. BHWS funding decisions must be based on the following:
   1. Availability of resources.
   2. A review of the request to determine if the member/enrollee is eligible to receive services.
   3. Verification that the need for funding approval is related to behaviors attributed to a psychiatric condition.
   4. Coordinated Care may request additional information from HCS or its designee if questions arise regarding services, providers or if there are questions about the assessment.
      a. If changes are made to the assessment or funding request, HCS or its designee will provide a corrected BHWS Request for MCO Funding form (DSHS 13-712) for signature.
   5. A review of the requested services to determine if the member/enrollee's needs could be met through provision of other available behavioral health services.
   6. Additional information, as necessary in making a decision about whether the above criteria are met, including Coordinated Care care management information systems, PRISM, conversation with the HCS/AAA worker, conversation with the member/enrollee's mental health provider and others involved, including Tribes and Indian Health Care Providers when applicable.

E. The consensus guideline document created and agreed to by all MCOs for funding level agreement.

F. Coordinated Care must adhere to the following funding timeframe requirements:
   1. Funding timelines should align with the CARE plan period. If a timeline is to be shortened, Coordinated Care must confer with HCS or its designee to discuss the reason for the change including if there is a significant change in condition that alters the level of need for BHWS.
   2. The start date can be adjusted to the date received by Coordinated Care at Coordinated Care's discretion if the requested start date is more than thirty (30) days before date of request.
   3. If the requested start date is less than thirty (30) days before the date of the request, Coordinated Care will back date to the requested start date.
   4. Coordinated Care may not have policies that inhibit Enrollees from obtaining Contractor funding approval.

G. Coordinated Care must respond within the following timeframes for funding requests:
   1. Coordinated Care or its designee must acknowledge the receipt of a funding request from HCS or its designee within two (2) Business Days.
   2. If the request is marked urgent the acknowledgement will be within one (1) Business Day.
   3. Coordinated Care or its designee must make a decision on complete requests from HCS within five (5) Business Days of receipt of a complete request.
   4. Coordinated Care and the local HCS office or its designee may mutually agree in writing to extend the five (5) Business Day requirement.
   5. If Coordinated Care does not approve the funding, Coordinated Care shall provide clear rationale in writing on the Request for MCO Funding form (DSHS Form 13-712) for why the request did not meet the criteria, and/or what services will be provided to the Enrollee when applicable.

H. When Coordinated Care denies approval based on the provision of other services, Coordinated Care shall collaborate with HCS or its designee regarding the reason for denial and written explanation of its Care Coordination efforts.

I. If a dispute arises amongst parties regarding a funding request or relating to services, the following process will be followed:
   1. All parties agree to participate in discussions when circumstances arise regarding disagreements pertaining to eligibility, effectiveness, and appropriateness of these supports. This may include: changes in psychiatric symptoms, environment and related risk factors.
   2. Disagreements regarding the need for BHWS approved funding and assignment of financial responsibility shall be worked out between the escalation contacts identified in the contact list for HCS/AAA or their designees and Coordinated Care.
   3. Coordinated Care agrees to participate in discussions and case staffing, as needed, to resolve differences.

J. When an Enrollee has funding approved for the plan period (typically one year) by Coordinated Care, but transitions to another Contractor during the same plan period, the receiving Contractor, whenever possible, will honor the funding approval of the previous Contractor for a period of 180 calendar days and up to the rest of the plan period to ensure Continuity of Care.

K. Coordinated Care shall provide ALTSA fiscal staff on the last day of each month, a spreadsheet of all Enrollees approved for BHWS funding by emailing to MCOBHOforms@dshs.wa.gov.

L. Coordinated Care will adhere to the following billing and payment process:
   1. HCS or its designee will authorize services in ProviderOne, upon receipt of Coordinated Care's approval of DSHS Behavioral Health Wraparound Support Request for MCO Funding form (DSHS 13-712).
   2. ALTSA will bill Coordinated Care monthly for the GFS cost of services. Invoices shall be generated and sent each month by the 25th.
   3. Coordinated Care shall review the invoice provided by ALTSA for accuracy. If Coordinated Care does not agree with any billed costs, it must provide a written dispute to ALTSA within fifteen (15) Business Days of each monthly billing.
      a. ALTSA will respond to Coordinated Care's dispute within fifteen (15) calendar days.

4. Coordinated Care shall provide a copy of the final ALTSA invoice to HCA, with a copy to ALTSA at MCOBHObilling@dshs.wa.gov, within fifteen (15) calendar days of agreement between ALTSA and Coordinated Care on the billed cost.
5. HCA will deduct the amount on the invoice from Coordinated Care's next monthly GFS payment.

M. Coordinated Care must provide the following documentation to DSHS, HCS or its designee on request:
1. The original funding request from HCS or its designee,
2. Any information provided by HCS or its designee including the CARE assessment,
3. A copy of Coordinated Care's determination and written response provided to HCS or its designee, and
4. A copy of the plan developed and implemented to meet the Enrollee's needs through provision of other services when approval funding has been denied based on Coordinated Care's determination.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy adopted. Previously WA.UM.42	11/19	11/19
Updated to reflect 2020 contract language. Reference updated.	04/20	04/20
Annual review. Reference updated.	04/21	04/21
Annual review. Reference updated.	03/22	03/22
Annual review. Changed policy number from WA.CP.MP.521 to WA.CP.BH.521. Reference updated. "Members" replaced with "members/enrollees"	03/23	03/23
Annual review. Renamed policy from "Behavioral Health Personal Care Services" in preparation for July contract change. Updated Description. Policy criteria rewritten to match new contract language. Reference updated. Changed policy number to WA.CP.BH.521 from WA.CP.MP.521 to reflect behavioral health nature of the policy.	04/24	04/24
Annual review. References updated.	03/25	03/25

References

1. Washington State Health Care Authority. *Washington Behavioral Health Services Integrated Managed Care Wraparound Contract*. Chapter 12.2. January 1, 2025, contract.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.