# Washington Medicaid Supplemental Clinical Criteria

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## Introduction & Instructions for Use

### Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

### Instructions for Use

When deciding coverage, the member's specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

Assertive Community Treatment (a.k.a. Program of Assertive Community Treatment, PACT, ACT): Program of Assertive Community Treatment (PACT) is a self-contained mental health program made up of transdisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. PACT services are individually tailored with each consumer through relationship building, individualized assessment and planning, and active involvement with consumers to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The PACT team is mobile and delivers services in community locations rather than expecting the consumer to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for consumers. The consumers served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. There should be no more than 10 consumers to one staff member on each urban team and no more than 8 consumers to one staff member on each rural team.

## Admission Criteria

- The member's condition indicates indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
    - The member primarily relies on the emergency room for behavioral health services.
    - Impairment of behavior or cognition interferes with Activities of Daily Living (ADLs) to the extent that the member requires significant support or assistance.

## Continuing Stay Criteria

- Ongoing assessment of symptoms and consumer's response to treatment.
- Modifying treatment to work with consumer within the consumer's contextual environment, i.e., to "meet consumer where consumer is at."
- Tracking, addressing, and documenting medication side effects.
- Providing education to the consumer and family about illness, meds, nature of treatment, etc.

## Discharge Criteria

- There is an inherent capacity and ability of the individual to recover and that is an expectation that PACT participants will get better and eventually not require PACT services.
- Discharges will occur when consumers and program staff mutually agree to the termination of services.
- Successfully reach individually established goals for discharge and when the consumer and program staff mutually agrees to the termination of services.
- Move outside the geographic area of the team's responsibility.
- Demonstrate an ability to function in all major role areas without requiring ongoing assistance from the program for at least one year without significant relapse when services are withdrawn.
- Decline or refuse services and request discharge, despite the team's best attempts to engage the consumer including efforts to develop an acceptable treatment plan with the consumer.
- Additional circumstances for discharge:
    - Death
    - Inability to locate the consumer for a prolonged period of time
    - Long-term incarceration
    - Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the PACT team that the consumer will not be appropriate for discharge for a prolonged period of time.

## Service Delivery

- There will be an initial assessment and treatment plan completed on the day of the consumer's admission to PACT by the team leader or the psychiatric prescriber, with participation by designated team members.
- The comprehensive assessment will be completed by a PACT team member and that the assessment is based upon all available information and completed within one month after consumer's admission.

- Treatment plans must be updated whenever there is a major decision point in the consumer's course of treatment (e.g., significant change in the consumer's condition or goals) or at least every 180 days.
- A comprehensive chemical dependency assessment will be conducted during the first month after a consumer is admitted to the PACT team.
- Each consumer will be assigned a primary practitioner who will be responsible for overall Service Coordination. The primary practitioner will be responsible for the following:
    - Ensuring treatment plan is written and kept current
    - Functions as lead provider of individual treatment services
    - Functions as lead worker with consumer's family
    - Responsible for maintaining consumer's chart, to include completion of treatment plan updates, maintaining consumer service authorization, completion of any required Outcome Data Forms, etc.
- The consumer is regarded as the owner of his or her treatment. This ownership shall include:
    - Taking a primary role in developing the treatment plan.
    - Playing an active and collaborative role in decision making regarding every aspect of his or her treatment.
    - The freedom to take risks.
    - Being empowered to learn, make mistakes, and rebuild life skills.
    - The freedom to make decisions and choices about their treatment and lives.
- Crisis intervention services will be provided to PACT consumers who are in crisis, provided in the least restrictive environment.
- The PACT team whenever possible will be the initial crisis responders, face-to-face or by telephone and whenever possible, a PACT team member will be present when a DMHP or external crisis provider is working with a PACT consumer.
- The PACT team endorses and supports the recovery aspects of supportive education and employment.
- Each consumer will be provided with support in activities of daily living and social and interpersonal relationships.
- The PACT team will facilitate and assist consumers in obtaining medical, dental care, housing, transportation, etc.
- The PACT team will provide education, support and consultation services to consumers and their families/supports.

# Inpatient: Institutes for Mental Disease (IMD)

## Please apply LOCUS/CALOCUS-CASII/ECSII AND the following state-specific requirements for Washington.

Institutes for Mental Disease (IMD): An institution for mental diseases such as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. An IMD is a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

### Admission Criteria

- The member's condition and /or the member's history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include the following:
    - A life-threatening suicide attempt;
    - Self-mutilation, injury, or violence towards others or property;
    - Threat of serious harm to self or others;
    - Command hallucinations directing harm to self or others.

  OR
- The member's condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:
    - A physical cause for the member's signs and symptoms cannot be ruled out in a less intensive setting;
    - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting;

OR

- The factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include:
- Impairment of behavior or cognition that interferes with activities of daily living (ADLs) to the extent that the welfare of the member or others is endangered;
- Psychosocial and environmental problems that threaten the member's safety or undermines engagement in a less intensive level of care;

OR

- The factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.
- For IMD, the member is either under the age of 21 or over the age of 65.
- For IMD the member meets all of the above criteria and will likely not need inpatient care for more than 15 days.

### Continued Stay Criteria

- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
  - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating);
  - Health-related services provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;
  - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

### Discharge Criteria

- An IMD admission is no longer than 15 calendar days or less within the same calendar month.

### Service Delivery

- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation within 24 hours of admission.
- During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.
- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

## Inpatient: Children's Long-Term Inpatient Program (CLIP)

Children's Long-Term Inpatient Program (CLIP): CLIP is an inpatient program that provides inpatient care for children and youth between the ages of 5-18 who need extended inpatient mental health services. CLIP services are intended to promote discharge from inpatient care, maximize treatment benefits, minimize the risk of readmission and increase length of time in the community. Optum's CLIP liaison is the primary contact for the treatment team and will manage cases from preadmission through discharge. In the case of a CLIP admission from a Washington Tribal Authority, Optum's liaison will work with the tribe during discharge planning to provide appropriate services to the member.

### Admission Criteria

- The member's condition and /or the member's history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include the following:
  - A life-threatening suicide attempt;
  - Self-mutilation, injury, or violence towards others or property;
  - Threat of serious harm to self or others;
  - Command hallucinations directing harm to self or others.

OR

- The member's condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:
  - A physical cause for the member's signs and symptoms cannot be ruled out in a less intensive setting;
  - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting;

  OR

  - The factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include:
  - Impairment of behavior or cognition that interferes with activities of daily living (ADLs) to the extent that the welfare of the member or others is endangered;
  - Psychosocial and environmental problems that threaten the member's safety or undermines engagement in a less intensive level of care;

  OR

- The factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.
- The member is under the age of 19 who is in foster care or in an out of home placement; and/or receiving services through a family-centered, community based coordinated care; or
- It has been determined that the member may benefit from CLIP services after being court committed for involuntary treatment for 180 calendar days.
- The member receives Rehabilitation Case Management throughout the CLIP stay in coordination with the treatment team.

## Continued Stay Criteria

- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
  - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating);
  - Health-related services provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;
  - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
- The facility continuously considers less restrictive treatment options during the member's stay.

## Service Delivery

- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation within 24 hours of admission.
- During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.
- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.
- Services include:
  - Ongoing assessment for discharge
  - Work toward admission into community mental health care
  - Integrated mental health treatment planning
  - Resource identification
  - Linkage to mental health rehabilitative services; and
  - Development of individualized services that promote continuity of mental health care.

# Intensive Behavioral Health Treatment Services

Intensive behavioral health treatment services are intended to assist individuals in transitioning to lower levels of care, including individuals on a less restrictive alternative order. These services are provided for individuals with behavioral health conditions whose impairment or behaviors do not meet or no longer meet criteria for involuntary inpatient commitment, but whose care needs cannot be met in other community-based settings

## Admission Criteria

The member's care needs cannot be met in other community-based settings due to one or more of the following:

- Self-endangering behaviors that are frequent or difficult to manage;
- Intrusive behaviors that put residents or staff at risk;
- Complex medication needs, which include psychotropic medications;
- A history or likelihood of unsuccessful placements in other community facilities or settings such as:
  - Assisted living facilities;
  - Adult family homes licensed;
  - Permanent supportive housing;
  - Supported living certified; or
  - Residential treatment facilities providing a lower level of services.
- A history of frequent or protracted mental health hospitalizations; or
- A history of offenses against a person or felony offenses that cause physical damage to property.

## Service Delivery

An agency providing intensive behavioral health treatment services must ensure services are provided:

- In a residential treatment facility licensed;
- By a multidisciplinary team including clinicians, community supports, and those responsible for discharge planning; and
- With twenty-four hour observation of individuals by at least two staff who are awake and on duty.

The agency may:

- Only admit individuals at least eighteen years of age whose primary care need is treatment for a mental health disorder that does not include a diagnosis of dementia or an organic brain disorder, but may include individuals who have a secondary diagnosis of intellectual or developmental disabilities;
- Only admit individuals who are capable of performing activities of daily living without direct assistance from agency staff; and
- Not admit individuals with a diagnosis of dementia or an organic brain disorder who can more appropriately be served in an enhanced services facility or other long-term care facility.

In addition to the applicable training requirements, the agency must train all direct care staff on how to provide services and appropriate care to individuals with intellectual or developmental disabilities, including:

- An overview of intellectual and developmental disabilities including how to differentiate intellectual or developmental disabilities from mental illness;
- Effective communication including methods of verbal and nonverbal communication when supporting individuals with intellectual or developmental disabilities; and
- How to identify behaviors in individuals that constitutes "normal stress" and behaviors that constitute a behavioral health crisis.

The agency must develop and implement policies and procedures that explain how the agency will have sufficient numbers of appropriately trained, qualified, or credentialed staff available to safely provide all of the following services in accordance with an individual's care plan and needs:

- Planned activities for psychosocial rehabilitation services, including:
  - Skills training in activities of daily living; skills training may include teaching and prompting or cueing individuals to perform activities, but does not include directly assisting individuals in performing the activities;
  - Social interaction;
  - Behavioral management, including self-management and understanding of recovery;
  - Impulse control;
  - Training and assistance for self-management of medications; and
  - Community integration skills.
- Service coordination provided by a mental health professional;

- Psychiatric services, including:
  - Psychiatric nursing, on-site, twenty-four hours per day, seven days per week;
  - Timely access to a psychiatrist, psychiatric advanced registered nurse practitioner, or physician's assistant who is licensed under Title 18 RCW operating within their scope of practice who by law can prescribe drugs in Washington state; and
  - A mental health professional on site at least eight hours per day and accessible twenty-four hours per day, seven days per week.
- Access to intellectual and developmental disability services provided by a disability mental health specialist or a person credentialed to provide applied behavioral analysis; and
- Peer support services provided by certified peer counselors.

The agency must provide access to or referral to substance use disorder services, and other specialized services, as needed.

The agency must provide a system or systems within the building that give staff awareness of the movements of individuals within the facility. If a door control system is used, it shall not prevent a resident from leaving the licensed space on their own accord, except temporary delays as allowed by (a) of this subsection. Such systems include:
  - Limited egress systems consistent with state building code, such as delayed egress;
  - Appropriate staffing levels to address safety and security; and
  - Policies and procedures that:
    - Are consistent with the assessment of the individual's care needs and plan; and
    - Do not limit the rights of a voluntary individual.

The agency must have a memorandum of understanding with the local crisis system, including the closest agency providing evaluation and treatment services and designated crisis responders to ensure timely response to and assessment of individuals who need a higher level of care.

The agency must develop and implement policies and procedures regarding discharge and transfer that:
- Allows each individual to stay in the facility and not discharge the individual to another facility type or other level of care unless another placement has been secured, and:
  - The individual completed their care objectives and no longer needs this level of care;
  - The individual has medical care needs that the agency cannot provide or needs direct assistance with activities of daily living;
  - The individual needs a higher level of behavioral health care, such as evaluation and treatment services, due to a change in behavioral health status or because the individual's conditional release or less restrictive alternative order is revoked; or
  - The individual is convicted of any gross misdemeanor or felony while being a resident in the facility where the conviction was based on conduct that caused significant harm to another individual residing in the agency or staff member and there is a likelihood the individual continues to endanger the safety and health of residents or staff. For the purposes of this subsection, conviction includes all instances in which plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence have been deferred or suspended.
- Allows individuals who are discharged to be accepted back into the facility if and when it is medically, clinically, legally, and contractually appropriate;
- Allows each individual to stay in the facility and not transfer to another agency providing intensive behavioral health treatment services unless the individual requests to receive services in a different agency certified to provide intensive behavioral health treatment services;
- Follows all transfer and discharge documentation requirements and also documents the specific time and date of discharge or transfer. Additionally, the agency must give the following information to the individual, the individual's representative, and family or guardian, as appropriate, before discharge or transfer:
  - The name, address, and telephone number of the applicable ombuds;
  - For individuals with disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals; and
  - The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.
- Includes transportation coordination that informs all parties involved in the coordination of care.

The agency must protect and promote the rights of each individual and assist the individual to exercise their rights as an individual, as a citizen or resident of the United States and the state of Washington. To do this, the agency must:

- Train staff on resident rights and how to assist individuals in exercising their rights;
- Protect each individual's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the agency;
- Post names, addresses, and telephone numbers of the state review and certification agency, the state licensure office, the relevant ombuds programs, and the protection and advocacy systems;
- Provide reasonable access to an individual by the individual's representative or an entity or individual that provides health, social, legal, or other services to the individual, subject to the individual's right to deny or withdraw consent at any time;
- Allow representatives of appropriate ombuds to examine a resident's clinical records with the permission of the individual or the individual's legal representative, and consistent with state and federal law;
- Not require or request individuals to sign waivers of potential liability for losses of personal property or injury, or to sign waivers of individual's rights;
- Fully disclose to individuals the agency's policy on accepting Medicaid as a payment source; and
- Inform the individual both orally and in writing in a language that the individual understands of their applicable rights in accordance with this chapter. The notification must be made upon admission and the agency must document the information was provided.

In addition to all other applicable rights, an individual receiving certified intensive behavioral health treatment services has the right to:

- Be free of interference, coercion, discrimination, and reprisal from the agency in exercising their rights;
- Choose a representative who may exercise the individual's rights to the extent provided by law;
- Manage their own financial affairs;
- Personal privacy and confidentiality, including the following considerations:
  - Personal privacy applies to accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.
  - The individual may approve or refuse the release of personal and clinical records to an individual outside the agency unless otherwise provided by law.
  - Privacy in communications, including the right to:
    - Send and promptly receive mail that is unopened;
    - Have access to stationery, postage, and writing implements; and
    - Have reasonable access to the use of a telephone where calls can be made without being overheard.
- Prompt resolution of voiced grievances including those with respect to treatment that has been furnished as well as that which has not been furnished and the behavior of other residents;
- File a report with the department for any reason;
- Examine the results of the most recent review or inspection of the agency conducted by federal or state reviewers or inspectors and plans of correction in effect with respect to the agency;
- Receive information from client advocates, and be afforded the opportunity to contact these advocates;
- Access the following without interference:
  - Any representative of the state;
  - The individual's medical provider;
  - Ombuds;
  - The agencies responsible for the protection and advocacy system for individuals with disabilities, developmental disabilities, and individuals with mental illness created under federal law; and
  - Subject to reasonable restrictions to protect the rights of others and to the individual's right to deny or withdraw consent at any time, immediate family or other relatives of the individual and others who are visiting with the consent of the resident.
- Retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents;
- Secure storage, upon request, for small items of personal property;
- Be notified regarding transfer or discharge;
- Be free from restraint and involuntary seclusion;
- Be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion;
- Choose activities, schedules, and health care consistent with the individual's interests, assessments, and plans of care;
- Interact with members of the community both inside and outside the agency;
- Make choices about aspects of their life in the agency that are significant to the individual;

- Unless adjudged incompetent or otherwise found to be legally incapacitated, participate in planning care and treatment or changes in care and treatment;
- Unless adjudged incompetent or otherwise found to be legally incapacitated, to direct their own service plan and changes in the service plan, and to refuse any particular service so long as such refusal is documented in the record of the individual;
- Participate in social, religious, and community activities that do not interfere with the rights of other individuals in the agency;
- Reside and receive services in the agency with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other individuals would be endangered; and
- Organize and participate in participant groups.

- The individual and their representative have the right to:
  - Access all records pertaining to the individual including clinical records
  - Be notified, along with interested family members, when there is:
    - An accident involving the individual which requires or has the potential for requiring medical intervention;
    - A significant change in the individual's physical, mental, or psychosocial status; and
    - A change in room or roommate assignment.

## Mental Health Services for Treatment Resistant Depression

Transcranial Magnetic Stimulation is a non-pharmacologic treatment for treatment-resistant depression covered for members age 18 and older who do not respond to antidepressant medications.

- Transcranial magnetic stimulation is a medically necessary treatment of major depressive disorder when the following are met:
- Failure of at least two different antidepressant medications from at least 2 separate classes at maximum tolerated dose for 4-12 weeks in separate trials.

  ○
- As initial treatment of a depressive episode (up to 30 treatment sessions, including tapering) and is administered according to FDA-cleared protocol
- Confirmed diagnosis of major depressive disorder with DX of F32- F33.9
- Patient is age 18 years or older.

- TMS is not considered medically necessary when:
  - Psychotic symptoms are present in the current depressive episode
  - Conductive, ferromagnetic or other magnetic-sensitive metals are implanted in the client's head which are nonremovable and are within 30 cm of the TMS magnetic coil. (Examples include: cochlear implants, implanted electrodes/stimulators, aneurysm clips or coil, stents, and bullet fragments.)
  - The client is diagnosed with Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder
  - Other neurological conditions exist (e.g. Epilepsy, Parkinson's disease, Multiple Sclerosis, Cerebrovascular disease, Dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, primary or secondary tumors in the central nervous system, or any other degenerative neurologic condition)
  - Used as a maintenance therapy
  - The client is an active substance user

- For further guidance please see the Optum Behavioral Clinical Policy: Transcranial Magnetic Stimulation https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies.html

## Reentry Targeted Case Management (rTCM)

Reentry Targeted Case Management (rTCM) is a person-centered, recoveryfocused approach to address the health of justice-involved Apple Health clients. rTCM is a mandatory service for the Reentry Initiative. rTCM is vital for the successful transition of clients reentering the community after incarceration. Reentry Care Managers play a significant role in supporting those leaving a carceral setting. Reentry Care Managers will:

- Assess a person's health care needs

- Develop Reentry Care Plans
- Support access to treatment, including but not limited to, SUD treatments of
- Medications for Opioid Use Disorder (MOUD) and Alcohol Use Disorder (MAUD)
- Facilitate referrals and transportation to treatment following reentry
- Connect clients to available health-related social needs (HRSN) services, including Apple Health-covered HRSN services

The intent of rTCM is to:
- Improve care transitions upon reentry into the community
- Increase continuity of health coverage
- Prevent unnecessary disruptions in care
- Reduce emergency department visits and inpatient hospital admissions
- Reduce decompensation, suicide-related deaths, overdoses, overdose-related deaths and all-cause deaths
- Lead to improved health outcomes in general

rTCM uses a whole-person approach, addressing physical, behavioral health, and HRSN. rTCM focuses on addressing health conditions which are prevalent in the individuals who are incarcerated. In particular, rTCM focusses on the following health conditions:
- Substance use disorders (SUDs), to include Opioid Use Disorder (OUD) and
- Alcohol Use Disorder (AUD)
- Mental health conditions
- Infectious diseases, including Hepatitis C and HIV

rTCM is voluntary for clients and is not a prerequisite to accessing other reentry prerelease services or Apple Health benefits.

## Admission Criteria

rTCM is medically necessary for a member who would otherwise be eligible for Apple Health if not for their incarceration status, has a diagnosis that corresponds with one of the ICD codes (Z65.1 or Z65.2), and who meets one of the following requirements:
- Is an inmate of a public institution, as defined in 42 CFR 435.1010, and are incarcerated in a state prison, tribal facility, county or city jail, or youth correctional facility.
- Was released from incarceration from a public institution, as specified by 42 CFR 435.1010, and was incarcerated in a state prison, tribal facility, county or city jail, or youth correctional facility within the last 12 months.
    - rTCM is medically necessary for each incarceration that the member experiences; therefore, the covered period prerelease is calculated from the most current estimated release date.

## Discharge Criteria

- The member **no longer meets medical necessity criteria** and no longer requires rTCM expertise for stabilization in the community, (i.e., expertise on reentry transitions and health impacts from incarceration are no longer needed to attain health goals) such as when the following components are completed:
    - Reentry Health Assessment
    - Discussion of health goals and development of Reentry Care Plan
    - Client informed of appropriate follow-up care
    - Providers identified and appointments scheduled
    - Coordination between carceral facility health care system and community providers
    - Reentry Warm Handoff, if appropriate (e.g., transition to another coordinator)
    - Post release date changed and is now exceeding 90 days.

- Examples of Indications for Discharge include when the member is ready to **transition to another coordinator** because the member:
    - Is eligible for and opts to enroll in, or is already enrolled in, a health home
    - Is eligible for and receiving another targeted case management service
    - No longer requires rTCM expertise (i.e., expertise on reentry transitions and health impacts from incarceration are no longer needed to attain health goals) and another coordination function is appropriate

- It is the member's choice to discharge from rTCM or is not able to be contacted.

### Exclusions

- The member is ineligible for Apple Health entirely or is ineligible for rTCM within the client's Apple Health coverage (e.g., clients who are served with rTCM at the start of incarceration and then have eligibility suspended due to a longer-term sentence).

### Service Delivery

Mandatory requirements (core elements) of rTCM include the following:

- Reentry Health Assessment to identify unmet care needs
- Reentry Care Plan developed according to Reentry Health Assessment
- Reentry Coordination according to the Reentry Care Plan. Includes scheduling, linkages to services, monitoring and follow-up activities to ensure the Reentry Care Plan is effectively implemented and needs are being addressed. Reentry Coordination requires routinely communicating with the client and others, including discussion with the client at a minimum of once per month in person, via audio-visual telemedicine, or via audio-only telemedicine. Additional activities may occur throughout the month to support the minimum requirements.
- Reentry Warm Handoff required if the Reentry Care Manager is changing (e.g., during prerelease period, pre to post Reentry Care Manager change such as to an MCO care coordinator or to a Health Home, etc.).
- rTCM must be delivered by a qualified professional, referred to as a Reentry Care Manager, acting within their scope of practice.
- The clinician may operate in a team-based model, delegating services within their scope of practice to other rTCM team members, which may include individuals with lived experience (e.g., certified peer counselors, community health workers [CHWs], etc.).
- Providers of rTCM must:
  - Meet the general provider requirements in Chapter 182-502 WAC.
  - Be enrolled with Medicaid, meeting all the following:
    - Have an individual national provider identifier (NPI)
    - Be enrolled in ProviderOne
    - Have a signed core provider agreement with HCA.
  - • Have the licensure to provide all the core elements of rTCM services. For core elements of rTCM, see What are the mandatory requirements to provide rTCM.
  - Bill HCA using only the allowed procedure codes published within this billing guide.
  - Ensure appropriate clinical oversight is applied when required by the scope of practice for the licensure type and when a service is delegated to another rTCM team member (e.g., certified peer counselors, CHWs, etc.).
  - Ensure duplicate billing does not occur. The activities performed by any rTCM team members who are Community Health Workers (CHWs), if billed to HCA, may not duplicate billing under the CHW services Apple Health benefit. rTCM providers may refer clients to Community Care Hubs for community supports and services. However, services delivered by Community Care Hubs within the MTP 2.0 HRSN Initiative are not billable as rTCM.

## Wraparound Services with Intensive Services (WISe)

WISe is designed to provide comprehensive behavioral health services and supports to members and their families up to 21 years of age with complex behavioral health needs. The goal of WISe is for the member to live and thrive in their home and community, as well as to avoid or reduce disruptive out-of-home placements.

The core elements of WISe include each of the following phases:

- Engagement
- Assessing
- Teaming
- Service Planning and Implementation
- Monitoring and Adapting
- Transition

WISe services are intensive or direct services provided in home and community settings. Intensive services ("direct services") provided in home and community-based settings. They are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a youth's functioning, or provided in order to maintain or restore functioning. Interventions are aimed at promoting health and wellness and helping the youth build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community.

Direct services are delivered according to an Individualized Service Plan, coordinated with the Cross System Care Plan to deliver integrated Wraparound with Intensive Services. The CFT develops goals and objectives for all life domains in which the youth's mental health condition produces impaired functioning (including family life, community life, education, vocation, and independent living) and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives seek to maximize the youth's ability to live and participate in the community and to function independently by building social, communication, behavioral, and basic living skills. WISe Practitioners should engage the youth in home and community activities where the youth has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service.

## Admission Criteria

The member is under the age of 21 and has complex behavioral healthcare needs that may include:

- Involvement in multiple child-serving systems (e.g., child welfare, mental health, juvenile justice, developmental disabilities, special education, substance use disorder treatment).
- More restrictive services have been requested, such as psychiatric hospitalizations, residential placement or foster care placement, due to mental/behavioral health challenges.
- Risk of school failure and/or who have experienced significant and repeated disciplinary issues at school due to mental/behavioral health challenges.
- Significantly impacted by childhood or adolescent trauma.
- Prescribed multiple or high dosages of psychotropic medications for mental/behavioral health challenges.
- History of detentions, arrests, or other referrals to law enforcement due to behaviors that result from mental/behavioral health challenges.
- Risk factors such as suicidal ideation, danger to self or others, behaviors due to mental/behavioral health challenges.
- Family requests support in meeting the youth's mental/behavioral health challenges.

## Service Delivery

### *WISe Screening*

- A WISe screen must be offered within 10 business days of receiving a referral.
- All WISe screens include:
    - Information gathering that utilizes the information provided by the referent (i.e. the youth, a family member, a system partner, and/or an informal or natural support). Additional information may be gathered from the youth and family directly and others who have been involved with the family (including extended family and natural supports) and/or its service delivery.
    - Completion of the Child Adolescent Needs and Strengths (CANS) Screen, which consists of a subset of 26 questions, pulled out the full CANS assessment. The CANS screen must be completed by a CANS-certified screener.
    - Entering the CANS Screen into the Behavioral Health Assessment System (BHAS) which will apply the CANS algorithm to determine whether the youth would benefit from WISe.
    - All youth who meet the CANS algorithm and the MCE's qualifying criteria will be determined to meet WISe level of care. If a youth does not meet the CANs algorithm, clinical judgment may be used to continue with a referral to WISe.
- Once the member has been screened into WISe, engagement includes steps to:
    - To lay the groundwork for trust and shared vision among the youth, family and WISe team.
    - To establish rapport and build commitment to WISe process through warmth, optimism, humor, and identification of strengths.
    - The WISe Practitioner(s) meet with the youth and family to explain the WISe process, and how it differs from traditional care.
    - The WISe Practitioner(s) obtains consent for services.

- The WISe Practitioner(s) discuss with the youth and family the events, circumstances, and moments that brought the youth and family to WISe.
- The WISe Practitioner(s) obtain the youth and family perspective on where they are presently (including listening for both their expressed needs and strengths), and where they would like to go in the future.
- The WISe Practitioner(s) discuss the youth's and family's view of crises, and develops a written plan to stabilize dangerous or harmful situations immediately.
- The WISe Practitioner(s) ensure the youth and family understand any system mandates (if applicable) and ethical issues.

### *WISe Assessing*

- The WISe Practitioner(s) complete a strengths discovery and a list of strengths for all family members.
- The WISe Practitioner(s) discuss and lists existing and potential natural supports.
- The WISe Practitioner(s) complete a list of potential team members.
- The WISe Practitioner(s) summarize the youth and family context, strengths, needs, vision for the future, and supports.
- The WISe Practitioner(s) determine with the youth and family how the CANS information will be provided to the team.

### *WISe Teaming*

- The WISe Practitioner(s) explain WISe to potential team members, eliciting their perspectives, and working to get their commitment to participate in the team process.
- The WISe Practitioner(s) invite potential team members to join the team process.
- The WISe Practitioner(s) partner and orient team members to the WISe process and team meeting structure.
- The CFT members help to create the team meeting agenda, provide input about the meeting logistics and provide comfort for youth and family.
- The CFT will include the youth, parents/caregivers (see definitions in Appendix B), relevant family members, and natural and community supports.
- The CFT will be expected to meet with sufficient regularity (every 30 calendar days, at a minimum), as indicated in the CSCP, to monitor and promote progress on goals and maintain clear and coordinated communication.
- The CFT reviews the interventions and action items and adjusts these accordingly, using the outcomes/indicators associated with each priority need, included in the CSCP. A WISe Practitioner guides the team in evaluating whether selected strategies are promoting improved health and wellness for the youth and successfully assisting in meeting the youth and family's identified needs.
- The CFT works together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and family.
- The CFT has a process to resolve disputes and arrive at a mutually agreed upon approach for moving forward with services.
- The WISe Practitioner(s) are expected to check in with team members on progress made on assigned tasks between meetings.
- The WISe Practitioner(s) set a time, date and location for the team meeting that is convenient to the youth and family.

### *Service Planning and Implementation*

- The WISe Practitioner(s) meet with the youth and family and develops a list of possible needs of the family prior to the team meeting, based on the results of the CANS assessment.
- The WISe Practitioner(s) convene one or more team meetings to discuss and obtain agreement on the elements of the CSCP.
- In the CFT meeting, the youth and family's vision for their future is presented.
- The CFT discusses and sets ground rules to guide the meetings.
- The CFT reviews and expands the list of strengths for the youth and family.
- The CFT creates a mission that details a collaborative goal describing what needs to happen prior to transition from WISe.
- The CFT reviews the list of needs and agrees which to prioritize in the CSCP, respecting and including the preferences and priorities of the youth and family.
- The CFT determines the intended outcomes that will transpire when the needs are met.
- The CFT brainstorms an array of strategies to meet these needs, and then prioritizes strategies for each need, including the use of natural supports and intensive services.
- CFT members agree upon assignments, or action steps, around implementing the strategies.

- The CFT evaluates the crisis plan and adapts as necessary.
- The work of the team is documented, and distributed among team members.

### *Monitoring and Adapting*

- The CFT continues to meet at a minimum of every 30 calendar days to evaluate progress towards meeting needs and the effectiveness of indicated strategies.
- The CFT adjusts strategies to meet changes in the needs and outcomes. The team adds, subtracts and modifies strategies to create the most effective mix of services and supports.
- The CFT evaluates whether there is progress towards the designated outcomes. The team adjusts the strategies to guide next steps.
- The CFT adds members, as necessary and appropriate, and strives to create a mix of formal, informal, and natural supports.
- The CFT celebrates successes and adds to strengths as they are identified.
- Full CANS assessments are administered and entered into BHAS every 90 days to help track progress, and to catch emerging needs and make changes to the plan as necessary.
- The WISe Practitioner(s) maintain ongoing communication outside of the team meetings to best monitor “buy-in”, and to ensure that all members’ perspectives are heard.

### *Direct Services and Settings*

- Direct services include, but are not limited to:
    - Educating the youth's family about the mental health challenges the youth is experiencing, and how to effectively support the youth.
    - In-home functional behavioral assessment.
    - Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the youth's family and others how to implement behavioral strategies, and in-home behavioral aides who assist in implementing the behavior plan, monitor its effectiveness, and report on the plan’s effectiveness to clinical professionals.
    - Therapeutic services delivered in the youth’s home or community including, but not limited to, therapeutic interventions such as individual and/or family therapy and evidence-/research-based practices (e.g., Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy, Family Functional Therapy, etc.). These services are designed to:
    - Improve self-care, by addressing behaviors and social skills deficits that interfere with daily living tasks and to avoid exploitation by others.
        - Improve self-management of symptoms including self-administration of medications.
        - Improve social functioning by addressing social skills deficits and anger management.
        - Reduce negative effects of past trauma, using evidence-/research-based approaches.
        - Reduce negative impact of mental health disorders, such as depression and anxiety, through use of evidence-/research-based approaches.
        - Support the development and maintenance of social support networks and the use of community resources.
        - Support employment objectives by identifying and addressing behaviors that interfere with seeking and maintaining a job.
        - Support educational objectives through identifying and addressing behaviors that interfere with succeeding in an academic program in the community.
        - Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.
- Direct services will be provided in any setting where the youth is naturally located, including the home, schools, recreational settings, childcare centers, and other community settings wherever and whenever needed, including in evenings and on weekends.

## References

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## Revision History

| Date | Summary of Changes |
|---|---|
| 12/2018 | Version 1. |
| 04/2019 | New RTF LOCG |
| 12/2019 | Revised to clarify LOCUS/CASII/ECSII |
| 08/2020 | Revised to clarify L/C/E used for RTF |
| 02/2021 | Revised to add Services for Treatment-Resistant Depression |
| 10/2022 | Annual Review |
| 12/2022 | Annual Review/Addition of IBHT |
| 12/2023 | Annual Review |
| 12/2024 | Annual Review |
| 06/2025 | Revised with rTCM |