SALISH BHO

CLINICAL POLICIES AND PROCEDURES

Policy Name: UNIFORM INPATIENT AND OUTPATIENT INTER-BHO TRANSFER PROTOCOL **Policy Number:**11.22

Reference: PHIP and State Contract; Inter-BHO Transfer Agreement

Effective Date: 7/01/2014

Revision Date(s): 6/2016

Reviewed Date: 6/2016; 6/2017; 5/2018

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plans
- Policy: Monitoring of Contractors
- Policy: Outpatient Discharge Planning

PURPOSE

The Salish Behavioral Health Organization (SBHO) shall ensure all transfers between BHOs are conducted in a standardized manner across the state.

DEFINITIONS

“Multiple” means, for the purpose of defining risk factors, multiple three or more.

“Referring BHO” means the BHO in whose region the individual resided and/or from whom they received services prior to state hospital admission.

“Receiving BHO” means the BHO into whose region the Referring BHO is pursuing the transfer.

“Risk factors” include the following:

- Transfer is being requested due to availability of specialized non-Medicaid resource.
- High inpatient utilization – 2 or more inpatient admissions in the previous 12 months, an inpatient stay in a community hospital for 90 days or more in the previous 12 months, or discharge from a state hospital in the previous 12 months.
- History of felony assaults, ORCSP eligibility, or multiple assaultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).
- Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia (the BHO would need to be involved even

though HCS might be arranging placement), and co-morbid serious medical issues.

"Specialized Non-Medicaid services" includes, for purposes of this protocol, IMD admissions, residential placement, and state hospital census.

PROCEDURE

BHOs in our state acknowledge and agree that:

1. Medicaid enrollees are entitled to Medicaid covered services in the community where they live.
2. Individuals who participate in mental health services have the right to freely move to the community of their choosing.
3. There are circumstances when an BHO (referring BHO) wishes to place an individual in another BHO's region (receiving BHO) to better meet the needs of that individual or moving to another BHO's region would allow the individual to be closer to family and/or other important natural supports.
4. Some individuals require specialized, non-Medicaid services to meet their needs.
5. Due to the scarcity of specialized, non-Medicaid services, these may not be immediately available upon the request of the transferring individual.
6. The receiving BHO assumes immediate financial risk for crisis services and Medicaid covered services at the time of transfer.
7. The referring BHO will continue the financial responsibility for "specialized non-Medicaid services" provided to the individual for the duration of time as determined by the number of risk factors identified at the time of transfer.

Number of Risk Factors	Duration
One risk factor	6 months
Two risk factors	9 months
Three or more risk factors	12 months

8. After completion of the risk factor time frame, the receiving BHO will assume all financial responsibility for the individual.
9. The referring BHO will retain the individual on their state hospital census until the individual is discharged. The referring BHO will accept on their census any individual placed in the receiving BHO who returns to the state hospital during the period of financial responsibility as defined above.
10. This protocol is intended to ensure a seamless transition for individuals with no more than minimal interruption of services.

Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol: Outpatient Services Transfers

1. If a Medicaid enrollee re-locates to a region outside of their current BHO they are entitled to an intake assessment in the new region and are then provided all medically necessary mental health services required in the PIHP contract, based on the BHO's level of care guidelines and clinical assessment.

2. When an enrollee is transferring to SBHO from another area, the receiving agency will contact the enrollee's current provider and request clinical records and other relevant information from that provider.
3. All Medicaid enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the PIHP. The availability of Specialized Non-Medicaid Services cannot be the basis for determining if the enrollee is offered an intake for services in the desired community of their choice.
4. There are circumstances when moving between BHOs is necessary to better meet the needs of the individual or moving to another BHO would allow the individual to be closer to family and/or other natural supports.
5. The receiving BHO will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.

When an enrollee is re-locating **and may benefit from specialized non-Medicaid services** beyond medically necessary services required in the PIHP, the BHOs agree to the following protocol:

a. The placement is to be facilitated by the joint efforts of both BHOs.
b. The referring BHO will provide all necessary clinical information along with the completed Inter-BHO transfer form.
c. The receiving BHO will acknowledge the request within 3 working days.
d. The receiving BHO will follow established procedures for prioritizing the referred enrollee and must offer an intake assessment to the enrollee for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.
e. The placement may not be completed without written approval on the inter-BHO transfer form from both BHO administrators, and their designees.
f. The receiving BHO shall make a placement determination within 2 weeks of receiving all necessary information/documentation from the referring BHO. The enrollee and the referring BHO will receive information regarding the placement policy of the receiving BHO for the specialized non-Medicaid service.
g. Placement will only occur when the specialized non-Medicaid service becomes available. If the specialized non-Medicaid service is not available at the time of the intended transfer, the receiving BHO will notify the referring BHO and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring BHO will keep the individual and others involved in the individual's care informed about the status of the transfer.
h. Payment responsibility for individuals transferring between BHOs will be described in this protocol and specified on the inter-BHO transfer form.

Uniform Transfer Agreement: State Hospital Inter-BHO Transfer Protocol

1. This section describes the inter-BHO transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.

2. Generally, individuals are discharged back to the BHO in whose region they resided prior to their hospitalization (designated by the state hospitals as the "BHO of responsibility").
3. For **all individuals in a state hospital** (regardless of risk factors) who intend to discharge to another BHO, an Inter-BHO transfer request is required and will be initiated by the BHO of responsibility (hereinafter referred to as the referring BHO).
4. The financial benefits section at the state hospital will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.
5. The placement is to be facilitated through the joint efforts of the state hospital social work staff and the BHO liaisons of both the Referring BHO and Receiving BHO.
6. A *Request for Inter-BHO Transfer* form and relevant treatment and discharge information is to be supplied by the Referring BHO to the Receiving BHO via the liaisons.
7. The Referring BHO will remain the primary contact for the state hospital social worker and the individual until the placement is completed.
8. The Receiving BHO will supply the state hospital social worker with options for community placement at discharge.
9. Other responsible agencies must be involved and approve the transfer plan and placement in the Receiving BHO when that agency's resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).
10. Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the individual, state hospital social worker or representative of the state hospital treatment team, liaisons, the mental health care provider from the referring BHO, and other responsible agencies.
11. Once the discharge plan has been agreed upon, the *Request for Inter-BHO transfer* will be completed within two weeks. The Receiving BHO has two weeks to complete and return the form to the Referring BHO. This process binds both the Referring and Receiving BHOs to the payment obligations as detailed above.

MONITORING

This policy is mandated by state contract.

1. This policy will be monitored through use of SBHO:
   - Annual Provider Chart Reviews
   - Grievance Tracking Reports

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