

EPSDT UPDATED PLAN 2002

In a recent report by the Joint Legislative Audit and Review Committee (JLARC) recommendation number 3 stated: “The Department of Social and Health Services Medical Assistance Administration (MAA) and the Mental Health Division (MHD) should revise the Early Periodic Screening and Diagnosis and Treatment (EPSDT) plan to reflect current mental health system structure”. As a first step to doing that MAA and the MHD sent a simple questionnaire to the field asking three basic questions with regard to EPSDT: what works well, what does not, and do you participate on the Regional Support Network (RSN) Over-site Team? The survey was sent to RSN Administrators, Community Mental Health Centers, Healthy Option Plans and Physicians. Thirty-three responses were received and the response rate was equal between mental health and physical health.

A summary of the results listed below shows:

What works well?

- Mutual referral process between mental health and physical health;
- Mental health providers are contacting primary care providers to rule out physical health care issues and open a dialogue;
- Successful teams and collaboration on cross-system issues (some include medication management);
- Use of the same provider network for counseling; and
- Early intervention with both physical and mental health issues.

What doesn't work well?

- Lack of physicians in both systems;
- Extra paperwork, complicated referral form;
- The data flag for the mental health system, these children would be served anyway in the public mental health system, this creates extra paperwork and administrative time away from direct service, and
- No report, collaboration/follow through between doctors and mental health.

Participation on the RSN over site team:

75% of the respondents did not participate

21% did and felt it some what beneficial

4% said children's issues were discussed in other forums and worked well. Some examples of these other meetings were the Healthy Options meetings, RSN Advisory Board meetings, Children Policy Groups.

In the current system, unlike when the original plan was written, the Mental Health Division contracts with the RSNs to operate a managed care system for mental health services. The operation of the prepaid health plan requires the RSN to serve Medicaid children whenever they met the definition of medical necessity. The Medical Assistance Administration operates both a managed care system under Healthy Options and a fee-for-service program. To track services to children receiving care under EPSDT both the MHD and MAA require a flag in their data systems, which identifies the child as one that has an EPSDT referral. While this flag appears to be an administrative burden for providers, it does provide information to the state and is used as a tool to meet federal requirements regarding EPSDT.

Based on the survey results and what we know from the field, we are revising the plan to:

1. Continue to maintain the open referral process and communication between physical and mental health care.
2. Continue to require the mental health system provide for at least 10% of the children served by two or more systems be staffed by child and family teams (described in the original plan) with active participation of the child, parent and their personal support network. This requirement will continue to be monitored through the use of satisfaction surveys, on-site monitoring and reports.
3. MHD, MAA, RSNs and Healthy Options Plans will jointly educate physicians on intensive community based mental health services that are available as alternatives to inpatient care. Included in this shall be information on the referral process for mental health services. This information may be located on web pages, brochures, and newsletters and through other means for broad dissemination.
4. The RSNs will continue identifying a children coordinator to facilitate communication between physicians and mental health clinicians.
5. Eliminate the RSN/EPSDT Over-site Committee as duplicative – we do, however, strongly recommend that children’s issues are on the agenda of the RSN Advisory Board and the RSN Governing Board when appropriate. In addition, we recommend RSNs and Community Mental Health Centers participate on Healthy Options Over-site Committees or Community meetings.
6. MAA will revise the current referral form with the intention of simplifying and clarifying the form and will be producing a final draft by June 2003 for field review and use.
7. The need for standardized reporting guidelines was suggested in the feedback to the survey. There were several responses that indicated follow-up reporting was a barrier to on-going services. One clarifying response suggested this could be a result of the confusion with the *referral* form. After an initial six-month test of the new referral form, MHD and MAA will survey the field to ascertain if follow-up barriers have been removed. If not, the MHD and MAA will convene a meeting with field representatives to discuss new steps to be considered.



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February 11, 1992

TO: Children's mental Health - Interested Parties

FROM: Jean Soliz, Senior Executive Policy Assistant

Yona Makowski, Senior Budget Assistant

SUBJECT: REPORT ON EARLY PERIODIC SCREENING DIAGNOSIS AND
TREATMENT (EPSDT)

Attached you will find the comprehensive plan for implementing the EPSDT system contained in federal Medicaid law. The plan also responds to legislative mandates to involve localized cross-agency planning for children; to maximize federal funds and to integrate the EPSDT system with the ongoing mental health reform efforts.

No legislation is required to implement this plan, but the Department of Social and Health Services is interested in your ongoing involvement as steps are taken to make this happen.

Thank you for your interest and involvement during this planning process.

EPSDT AND THE MENTAL HEALTH SYSTEM EXECUTIVE SUMMARY

BACKGROUND

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is Medicaid's preventative health screening program for children under the age of 21. Federal regulations require that any medically necessary treatment of problems identified during a child's EPSDT screen be provided through Medicaid. This includes mental health services. Although Medicaid eligible children are able to receive mental health treatment from community mental health centers and psychiatrists, as well as psychological evaluations from psychologists, these services are limited. Concern about meeting federal mandates and a desire to strengthen mental health services for children prompted the state legislature to pass SHP 1608 and SSB 5670 in 1991. This legislation commissioned a plan for the use of EPSDT in the provision of children's mental health services. It requested the development of a delivery system not only for integrating EPSDT and children's mental health services, but also ways to increase the number of children served, maximizing Title XIX funding and coordination the efforts of child-serving agencies. Required components of the plan include: a) criteria for screening and assessment; b) criteria for determining appropriate level of services; c) qualifications of providers; d) cost control mechanisms; and e) mechanisms to ensure federal matching funds are obtained.

Currently, Regional Support Networks (RSNs) or counties administer local mental health dollars, receiving funds from the state Mental Health Division (MHD), Department of Social and Health Services. Each RSN must provide Resource Management Services (RMS) and act as a gatekeeper. This ensures access to the mental health system by those most in need. RMS provides oversight to individuals receiving coordinated treatment plans, including supportive services. Other social service agencies, including the school system and child welfare, play essential roles in the delivering mental health services to children (and have received legislative funding to this end). This plan seeks to involve all the pertinent local (formal and informal) child (and family) serving systems in delivering integrated mental health services to children and their families in a culturally-sensitive and appropriate method, while at the same time, control costs and take advantage of federal funding streams.

PLAN

All Medicaid funded services for children will be provided under the oversight of a multi-system collaborative committee, with the services of each system integrated as necessary to meet the unique needs of the child and family. While some children will

only require the services of one system, the provision of this care will be consistent with the local area's design.

Children who have been identified during an EPSDT screen as needing mental health services will be referred to the RSN for assessment. The RSN will arrange for an assessment and determine whether the child is: a) Priority or non-priority (in accordance with state rules and regulations); and should receive b) Level I or Level II services.

Level I children are defined as those with minimal needs for service. These children will be referred to RSN-contracted providers for short-term services according to an individual (but family-centered) plan developed by the resource manager. If the child needs services beyond the original authorized level, they may receive additional Level I services (within certain parameters) or be elevated to Level II. Level II children are defined as priority population children in need of intensive services and involved with more than one service system. Level II services consist of intensive, longer-term community-based options, integrated across all service systems involved with the child. The service plan is developed for the child in the context of his or her family and is designed by an individualized, child specific service team made up of representatives from the different child serving systems who are actually involved with the child, along with the family. The cross system plan will be reviewed and approved by Resource Management Services and other local participating agency administrators. The RSN will ensure overall coordination with all councils within the community assisting with children and family needs.

Medical Assistance Administration (MAA) will explore the possibility of transferring its appropriation for children's psychological evaluations, psychiatric treatment and inpatient hospital services to MHD. This funding, along with administrative match for the authorization functions, could be used to cover these new responsibilities. Cost controls will include prior authorization of a treatment plan and reviews of treatment through performance-based contracts. State services will be maximized with federal matching funds where possible.

At this time, it appears that no additional legislation will be needed to implement this plan. Implementation of the plan will require adequate phase-in time. Services will be transitioned in phases:

Phase I

- * Dec. 1, 1991 -- Medical Assistance Administration increases outreach to school districts.

- * Dec. 1, 1991 -- Division of Children & Family Services establishes EPSDT workgroup.

- * Jan. 1, 1992 -- Education Service District 112 will develop a marketing strategy to educate and solicit school districts' participation in Medicaid covered services.
- * Jan. 1, 1992 -- Explore possibility of transferring MAA funds for children's mental health to MHD.
- * April 1992 -- The state-level multi-disciplinary team will be established to set criteria for service levels and assessments.
- * July 1, 1992 -- EPSDT children referred to RSNs for community support services at community mental health programs will be given priority for evaluation and services over Medicaid children who self-refer.
- * July 1, 1992 -- Amendments to existing agreements with RSNs and counties will be completed.
- * July 1, 1992 -- Referral forms from EPSDT screeners to RSNs will be disseminated. Medicaid children may continue to self-refer to community mental health centers and other mental health providers.
- * July 1, 1992 -- Ongoing Technical Assistance/Consultation and Team Building Training will be available at community level.
- * July 1, 1992 -- Explanatory materials and planning guidelines related to EPSDT issued to local mental health authorities and allied child-serving systems.
- * Aug. 1, 1992 -- Complete exploration of transferring MAA funds for children's mental health to the MHD. (may be incorporated in the 1993-95 Biennial Budget)
- * Oct. 15, 1992 -- Local plan for implementation of EPSDT will be submitted in accordance with SHB 1608.

Phase II

- * Jan. 1, 1993 -- State medical assistance plan will be amended to allow licensed psychologists to contract with RSNs to do assessments and/or provide Level I services for children only Medical Assistance Administration increases outreach to school districts.

- * Jan. 1, 1993 -- EPSDT Resource Managers will be hired or designated by each RSN and county.
- * Jan 1, 1993 -- Referrals from EPSDT screeners for mental health assessments regarding level of service and treatment planning will begin coming through Resource Management.
- * Jan. 1, 1993 -- Evaluation planning begins.

Phase III

- * July 1, 1993 -- The new delivery system will be in place with 10% of Level II children in services seen by child-specific teams.
- * July 1, 1993 -- No self-referrals of Medicaid covered children permitted. All children will be required to access mental health services through an EPSDT screen.

Phase IV

- * July 1, 1994 -- Plan and incremental time-lines leading to full implementation will be submitted by RSNs and allied child-serving systems.
- * July 1, 1994 -- Implementation material from evaluation available.

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conceptual framework.

EPSDT AND THE MENTAL HEALTH SYSTEM

III. INTRODUCTION

Many children in the state of Washington suffer from various forms of mental illness. They lack the ability to cope with the daily challenges and social interactions of life. They experience thought and mood disorders. They also exhibit overt emotional and/or behavioral problems. Without proper and immediate attention, these children often have to be placed out of their own homes and communities in a hospital, residential and/or institutional setting. Schools may be required to offer special services within the school setting, to deal with their behavior and learning difficulties.

Recognizing the need for both collaborative and innovative methods of utilizing existing service modalities, the legislature has acted to improve access to mental health services.

Legislative desire to strengthen mental health services for children led to passage of SHB 1608 and SSB 5670. As a result, the Office of Financial Management (OFM) has been directed to submit to the legislature by December 1, 1991, a plan with criteria for the use of Title XIX's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program as it relates to children's mental health. Certain elements were indicated as necessary components of the plan:

- A. Criteria for screening and assessment of mental illness and emotional disturbance;
- B. Criteria for determining the appropriate level of medically necessary services;
- C. Qualifications for children's mental health providers;
- D. Cost control mechanisms; and
- E. Mechanisms to ensure that federal matching funds are obtained.

OFM developed this plan in consultation with an interdisciplinary committee of staff from the Medical Assistance Administration, and the Mental Health Division. Other child-serving divisions within the Department of Social and Health Services (DSHS) also provided input. The task of the interdisciplinary committee was to develop a plan to integrate screening, diagnosis and treatment needs of Medicaid-eligible children, with services available through the mental health system.

There has also been extensive input from local service system managers and direct service providers. Regional Support Networks (RSN) and other affected community members analyzed this plan and were given the opportunity to provide input. The plan was reviewed by major stakeholders within DSHS, the mental health system, the educational system, and other interested parties across the state.

This plan emphasizes local responsibility of the RSNs in providing care and attempts to expand mental health service delivery while maximizing federal dollars. This expansion is designed to ensure that children receive services which are appropriate to their needs, community-based, family-centered, less restrictive, less costly and tied to specific outcomes based on a uniform definition of medical necessity.

Included are tracking mechanisms for accountability and flexible controls. In addition to the criteria specified by the legislature, the interdisciplinary committee developed a set of desired criteria for a plan to serve the children identified through EPSDT as needing mental health services. As a result, this plan is based on the following criteria:

- Allows for incremental funding additions;
- Works within the mental health system undergoing reform, e.g. involves the RSNs
- Has a mechanism for interagency collaboration in development and oversight of Medicaid funded services and participation for multi-system children;
- Relies on the local community to pliant implement and monitor treatment for each individual child;
- Increases the system's capacity to serve children appropriately and responsively in a family-oriented, culturally sensitive, and community-based way;
- Provides a tracking mechanism;
- Maximize federal funds; and
- Has standards of care.

Mental health services to children should be structured in ways that are culturally and age appropriate and involves the family. Children of color are especially underserved in the current mental health system, despite their increased risk for emotional disorders due to the multiple stresses of poverty, language barriers, racism, and inadequate family support services. This plan allows for regional flexibility to strive for parity and equity of services for children of color.

IV. BACKGROUND: DESCRIPTION OF EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a preventive health care benefit for Medicaid recipients under 21 years of age. EPSDT became a benefit of the Title XIX Medicaid program in 1967 nationally, and in 1972 in this state. While it is mandatory for the state to offer the service, the state cannot require parents to avail themselves of this service on behalf of their children. There are certain federal requirements, but states have flexibility in how they choose to administer it. It is important to note that EPSDT does not have its own allocation; its funding is subsumed within the Medicaid services.

In Washington State, EPSDT is known as "Healthy Kids". The Washington Medicaid Program covers virtually all groups of children allowed under federal law. Appendix A displays the eligibility parameters.

EPSDT Services

The goal of EPSDT is to provide a comprehensive and periodic assessment of a child's overall health, developmental and nutritional status. The objective is to treat conditions and illnesses disclosed during the assessment process. EPSDT helps facilitate children getting into a "medical home"--a primary care provider who will see them over time and manage their health care. That makes EPSDT a very important mechanism for detecting and treating problems early.

In Washington, children can receive screens annually to detect any problems with the children's general health and development. (More frequent screenings are covered for infants and toddlers.) Physicians, Advanced Registered Nurse Practitioners (ARNP), rural or migrant health clinics, or health departments can all conduct EPSDT screening. Public health nurses are being trained to do screening in areas of the state without adequate providers. Children are also entitled to an annual vision exam, hearing screen and biannual dental examinations. If a disorder is suspected, the child can receive additional partial screens to rule out the problem, even if a screen has already been given in the past year.

Screening Components

EPSDT consists of four screening elements--health, dental, vision and hearing. It offers treatment for medically necessary health problems identified during the screening and assistance with transportation and scheduling appointments. These components need to be available in accordance with a "periodicity schedule;" a routine schedule of physical exams sequenced as recommended by medical professionals. "Interperiodic" screenings are also possible so that a suspected health problem can be identified and treated at any time.

Screening components include:

- A. A comprehensive health and development history, updated at each screening examination;
- B. A comprehensive unclothed physical examination performed at each screening examination;
- C. Vision and hearing tests (can be obtained separately);
- D. Appropriate laboratory tests, including blood lead level testing;
- E. Immunizations according to age and health status;
- F. Maintaining records of the child's developmental progress, significant physical findings, immunizations, and any treatments or referrals.

In addition, all children over three years of age are to be referred to a dentist. Children under three may be referred to a dentist if a problem is suspected, i.e. baby bottle teeth.

Other necessary health care to correct or ameliorate defects and physical illness discovered during the screening is to be provided.

This plan proposes to strengthen the developmental and mental health component of the screen.

Program Administration

In Washington, EPSDT is administered statewide through the Medical Assistance Administration. MAA staff coordinate with other DSHS programs, health departments, schools, Community Service Offices (CSO), other state agencies, and the local communities to promote EPSDT. MAA offers transportation to a medical appointment arranged through a statewide broker system when the client has no other means. Assistance finding a provider to perform an EPSDT screening is offered through the MAA Recipient Toll-Free Line.

Federal Financial Participation (FFP) is available for the administrative (as distinguished from fee-for-service) functions of EPSDT such as doing outreach and notification, locating providers, arranging transportation, or providing prior authorization. A 75 percent match is available if the administrative task is a medical function performed by a physician or nurse. Such tasks might include doing assessment of the mental health treatment needs and authorizing services. Some of the administrative functions which are the responsibility of the single state Title XIX agency (currently DSHS) can be delegated.

V. IMPROVING THE UTILIZATION OF EPSDT

Utilization in Washington

The federal Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated states to increase availability, expand eligibility, and augment services to low-income Medicaid eligible children. OBRA '89 also contains a provision requiring the state to pay for necessary treatment of conditions discovered during the screen, including optional Medicaid services, whether or not the service is included in the State Plan.

Because Washington has a very comprehensive Medicaid program, it is not as impacted by this provision as are other states. Nevertheless, Washington is vulnerable to violating federal mandates in the provision of mental health services to children. Washington lacks mechanisms to ensure that medical providers who identify mental health problems are able to link children with necessary treatment. In addition, the capacity of the mental health system to serve children in need is limited. Further, the mental health system is mandated to serve children according to criteria, which define priority populations: acutely mentally ill, severely mentally ill, and seriously disturbed.

OBRA '89 also mandates that, by the year 1995, eighty percent of all children and adolescents eligible for EPSDT receive a screen each year. The current utilization rate in Washington is 23 percent (Appendix B). Statistically, rates are higher for infants and toddlers; then the rates drop significantly. Utilization rates rise slightly for school entrance-age children and at ages when children need sport physicals but generally remain low. Thus, school age children, those most likely to need mental health services, are the ones least likely to get screened.

Strategies to Improve Utilization

A number of strategies are currently underway to improve EPSDT utilization. Medical Assistance Administration has concentrated its efforts to increase the utilization of EPSDT in six major areas:

A. Marketing

Department of Social and Health Services/Department of Health are working collaboratively to increase participation in children's health programs including EPSDT. A Children's Marketing Committee is in place to identify and develop outreach materials and an information campaign.

B. Outreach to Community Services Offices (CSO)

Since all EPSDT eligible children come in contact with a CSO, the need for interagency coordination with Economic and Medical Field Services (EMFS) is great. As a part of the strategy to better market the Healthy Kids program, MAA works with the CSOs to make Healthy Kids brochures available; provides Healthy Kids program information to CSO staff; and provide in-service presentations to some of CSO financial and social workers.

Staff of EMFS and MAA have also worked on developing a pilot project to investigate the usefulness of placing workers in the CSOs to perform EPSDT outreach. Social workers trained in EPSDT case find and assessment would explain Medicaid benefits, schedule appointments for screening, work with families for follow-up, and perform other case management activities. When funding was available for EPSDT staff in the CSO's, screening levels were at 44 percent. However, that funding was discontinued in 1981.

Staff of MAA and EMFS are now exploring the feasibility of soliciting local health departments to perform EPSDT outreach. CSO staff would refer Medicaid eligible children to the local health department. Health departments could obtain administrative match for outreach efforts and reimbursement for performing screening thereby expanding their source of revenue.

C. Outreach through Division of Children & Family Services (DCFS)

Staff of MAA and DCFS are working together to provide updated training to DCFS workers in the field. An internal DCFS workgroup regarding EPSDT was established in December 1991. The workgroup is focusing on identifying strategies to increase utilization of EPSDT by training staff, providers, and foster parents on how to access screenings and services. All children in foster care, as well as many receiving adoption and family reunification services through DCFS are eligible for Title XIX, therefore, also eligible for EPSDT services.

D. Enhanced billing procedures and reimbursement rates

Effective September 1, 1990, Medicaid program reimbursement rates were increased for primary health care services to children. Rates for office visits, Healthy Kids screenings, and routine newborn care in the hospital were increased to improve children's access to primary health care. Also, billing procedures were simplified to make it easier for providers to obtain reimbursement.

In addition, providers have received training on billing procedures. Billing instructions have been condensed. Paperwork has been reduced. Providers are encouraged to request technical assistance in billing whenever it is needed.

E. Outreach to Schools

MAA and Office of Superintendent for Public Instruction have been working on EPSDT and Medicaid issues for several years. Recently, MAA and educators' conferences have been initiated to explore further opportunities of working together. Methods of obtaining federal match for the services provided to children in the schools are being developed. Children within the school system are receiving health care services that may be reimbursable under Medicaid. MAA is working to identify potential Medicaid-reimbursable services within schools. These might include services provided by school nurses and counselors. MAA and OSPI have written a medical resource pamphlet for schools describing the various medical programs for children, including EPSDT. In addition, MAA has been exploring ways with OSPI to link recipients of free and reduced cost school lunch programs with medical assistance and EPSDT. A staff person within MAA is responsible for informing school districts about the opportunities available to them and then working with individual districts to implement matching procedures. MAA has also worked with schools and health departments to provide services to school age children through mobile vans and a school-based clinic.

Examples of match taking place in schools include:

- The 1989 Legislature passed SHB 2014, authorizing the Office of Superintendent of Public Instruction (OSPI) and DSHS to establish a process by which school districts can obtain reimbursement for Medicaid-covered services, potentially including some mental health services (psychological evaluations), provided to qualified special education students. The program is designed to provide billing procedures, the provision of necessary training to educational service districts and school district personnel, and reimbursement for qualified Medicaid services now being offered to certain children in schools. Eighty of 297 school districts currently take advantage of or plan to take advantage of this program. ESD 112 has recently taken the leadership in marketing this program to other school districts. ESD 112, OSPI, and MAA will work together to assist other districts in setting up a system to obtain Title XIX match where possible. A summary of claims paid under the SHB 2014 project through October 1991 is attached. (Appendix F).

- School nurses who work in teen parent programs have become case management providers for pregnant and parenting teens, and bill MAA for services provided.

F. Community Outreach

In addition to focusing on the CSOs and schools, other resources within the community have been included. In a continuing effort to promote EPSDT services, Healthy Kids presentations were made at various child-serving system; such as:

- Community forums;
- Foster Parent groups;
- Birth to Six Family Resource Coordinators;
- Washington Education Association Conference; and
- Rural Health Care Workers training groups

MAA staff actively participate in several groups that work on children's health issues.

VI. INTEGRATING MENTAL HEALTH SERVICES FOR CHILDREN

Inclusion of mental health services in the EPSDT program provides an excellent opportunity to integrate services for children across the multiple child-serving systems. This process of service integration is consistent with the goals and objectives of the Family Policy Initiative. Similarly, this plan is committed to coordinated services that are locally planned and community based. In order to provide a coherent and tailored response to each child, the structural barriers between the systems must be understood and resolved. Many efforts are underway in local communities and at the state level to create "seamless" care for children and their families -- to fill the cracks between family service systems. This integration of services is not easy. It is, however, essential to provide the effective response each child and family deserves.

The following describes some aspects of the various services systems involved in providing services for children and their families. It identifies structural issues and recommends resolutions.

Mental Health

While MAA has been working to meet the requirements of OBRA '89, the Mental Health Division has been challenged to meet its own mandate for system reform.

On May 3, 1989, Governor Booth Gardner signed Second Substitute Senate Bill 5400 (2SSB 5400). The bill represents sweeping reform for Washington State's mental health system.

The goal of this reform is to provide a coordinated array of services, supports, and opportunities-that will allow individuals experiencing mental illness to stay in their communities with dignity and achieve their highest potential.

- It moves the authority and responsibility for planning, developing, and administering mental health services from the state to communities by allowing a county or group of counties to form Regional Support Networks (RSNs). Accountability to the state is maintained through performance-based contracts.
- Each RSN must provide Resource Management Services (RMS) to act as a gatekeeper, which ensures access to the mental health system by those most in need. RMS must see that individuals receive an integrated and coordinated plan, based on their preferences. The plan should include resources for: housing; treatment supports to minimize acute crisis; income supports; and services to address the needs of underserved populations, including children, ethnic minorities, disabled, etc.
- RMS also must identify a single entity, such as a case manager with primary responsibility for effective implementation of each person's plan.

From its inception, the community mental health system has provided services to children and their families. Children's services are included in the current reform of the system. Although many adults and children within the state-defined priority populations go unserved, many areas of the state include children on their caseloads at the same rate that children appear within the population. Others are still working to achieve this goal.

As programs seek to meet their mandates, they must develop a delivery system, which will meet the needs of Medicaid and non-Medicaid children for mental health treatment while honoring the spirit of mental health reform.

Payment Mechanisms For Mental Health Services For Medicaid-Eligible Children

Currently, Medicaid eligible children receive mental health services in two ways:

A. Fee for Services Reimbursement through MAA

- Inpatient hospital care
- Psychiatrist (one hour a month)

There are strict limitations on outpatient psychiatric services and the Medical Assistance program does not cover independently practicing psychologists (except for evaluations) or psychiatric social workers.

B. Community Mental Health Systems/RSNs

Money goes from the MHD to RSN and non-RSN counties in a block grant to cover populations needing mental health services. The RSNs contract with licensed community mental health providers to provide services. The RSNs are mandated to serve clients in the priority population. The priority population for children is described in Appendix C. The state match is lidded, but local funds from county revenues may also be used to match Medicaid funds to provide services. (In October 1992, new regulations regarding local match will be implemented.) The claims for the Medicaid recipients are paid through Medicaid Management Information System (MMIS) and federal Title XIX match is obtained.

Most Medicaid recipients receive care from licensed community mental health centers. Persons most in need receive services first, leaving little or no capacity for non-priority populations. No state mental hearth funds can be used for non-priority population clients. Local funding may be used to serve' these clients. In addition, new Medicaid rules will further limit the amount of funding available to serve this population.

In addition, Medicaid children may be receiving services through other systems such as schools and DCFS. These services may or may not be receiving Title XIX match. The inventory mandated by SHB 1608 has identified mental health services provided through any state-funded system. Matching funds will be sought where possible.

Resolving System Issues Between Medicaid and Community Mental Health

In order to integrate a response to children in need of mental health services through EPSDT with the current community mental health system, there are inevitable problems to be resolved.

A. Priority Population vs. Medical Necessity

One of the principles of mental health reform is that the mental health system focus on priority populations clients most in need and those most likely to be hospitalized. This is in contrast with the Medicaid, which entitles all eligible children to necessary treatment services regardless of diagnosis or client characteristics. Diagnosis can't be used to limit or deny services according to federal Medicaid rules. Services under Medicaid are governed by the principle of "medical necessity", which has been defined through a consent order as:

"Medical necessity" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions 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 recipient requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Recommendation:

This plan provides a process to identify all children with a medical need for mental health services. Children within the priority populations remain the responsibility of the RSNs. Funding may be transferred to RSNs from the Medical Assistance Administration budget to serve non-priority children. Priority and non-priority children may also be served through schools and DCFS.

B. Single Point of Responsibility vs. Freedom of Choice

A single point of responsibility, a theme of mental health reform aimed at improving coordination of care, is in contrast to the freedom of choice tenet of Medicaid. The Medicaid client's right to choose a provider is protected by federal law. This freedom can only be restricted through the granting of a federal waiver. Waivers must demonstrate cost effectiveness in order to be granted.

This means that a client in need of mental health services may choose to receive these services outside of the mental health system, even though this program design may rely on all children being served in a coordinated fashion through the same system.

For example, if a client needs mental health services and wishes to use a licensed psychiatrist, rather than the mental health system, the client cannot be forced to use either the RSN or a specific psychiatrist. The state is able to specify the qualifications of providers who may deliver particular services. The qualification of providers must be reasonable and not arbitrary. Generally, the qualifications are related to licensing, education and training and are set in consultation with other medical professionals.

Recommendation:

The RSNs will use a variety of providers and allow families to choose a service provider from the list of qualified providers who opt to provide service to Medicaid eligible children through the RSNs. There will be a single point of entry, but a multitude of providers can be used. Children and their families can select providers from within the provider pool. Specific implementation parameters will be developed in conjunction with the RSNs.

C. Lidded State Match vs. Entitlement

The state mental health program operates under a lidded funding structure. RSN and non-RSN counties receive an allocation from the state and must provide services within that allocation. In contrast, Medicaid is an entitlement program. All children in need of assistance must be able to receive necessary services.

Recommendation:

If we had unlimited resources, appropriate integrated services would be immediately available for all children who need them. This means that some children will wait to receive the services they need. Federal authorities find this an acceptable strategy for compliance with the EPSDT mandate, as long as there is a reasonable expectation that the child will receive services and a reasonable priority system.

D. Public Schools

Public schools provide numerous services to children in addition to strictly defined educational instruction. School counselors and intervention specialists play an important role in supporting children and their families through many difficult situations. Recent legislation has encouraged schools and the state's Medicaid system to find ways of securing federal match for covered services to eligible children. Schools must provide appropriate educational services to all children, even those who have serious behavior problems.

About 20-25% of the state's school children are Medicaid eligible. Service delivery in schools must be designed to meet the needs of all children in school, and can't be driven by a need to claim federal match for a portion of the population.

Mental Health Services Provided by Schools

In order to provide the best services to children and their families, there is a need to assure that mental health services currently provided by schools are integrated with those of the other child-serving systems. This is especially important for children in need of intensive treatment services and those actively involved in multiple service systems.

The definition of mental health services used by the schools is different from definitions used by health professionals. Schools have a unique codified definition of "behaviorally disordered" (see Appendix G). More of a preventative emphasis is possible in school setting--services that are not typically reimbursed by Medicaid or other third party insurers.

The issue of definitions becomes even more pronounced when integrating with special education rules and funding. If children are identified by non-educational systems as functionally impaired due to a mental illness, this may cause problems if the schools have not identified the children as special education students. Parents may use the diagnosis obtained through the mental health system to obligate schools financially and to demand that their children be treated according to the school's special education guidelines.

Recommendation:

It is not yet clear how to differentiate between the services, which must be integrated, while enabling schools to do their difficult job. The plan will be developed to accommodate schools as much as possible. Planning guidelines collaboratively developed with representatives of education will be issued by July 1, 1992, to provide direction to local planning efforts.

E. Child Welfare and Other Child-Serving Systems

The need to integrate services for children and their families encompasses all of the public and private organizations, which provide the services. Each of these entities has its own primary focus, history, and culture.

An effective way of bringing together all of the people working with a child and family in order to operate from a consistent, mutually-developed plan is essential.

Recommendation:

Later portions of this plan propose a detailed process, which will further system integration at the administrative level and identify a specific support team for each child and family.

F. Licensing Differences Among Services Systems

MAA relies on state licensing and/or state certification as the criteria for a "qualified provider" in the Medicaid program. In addition, Medicaid recognizes the credentials of individual providers, not the facility in which they work. There are some providers who are used by other systems, and cannot be reimbursed under Medicaid. The community mental health system, in contrast, may rely on education and training rather than licensing to define a qualified provider, and further requirements may be required by the RSNs or counties. Schools rely on certification through the educational system. These certified providers may not be licensed or may not meet the criteria outlined by the RSNs for mental health providers. Some of these criteria are required by the federal or state entity funding each system. There are some providers who can only be paid by all systems and some providers who can only be paid by a single system. For example, schools employ certified professionals, whereas Medicaid only reimburses state licensed professionals.

Recommendation:

These constraints will need to be considered in order to maximize federal funds and expand capacity to serve children.

School Psychologists

School psychologists are certified and currently do not meet licensing requirements as defined by state law. Psychological evaluations are currently reimbursable by Medicaid if they are performed by a licensed psychologist. In an effort to maximize federal matching funds and expand the number of available providers, MAA is exploring the possibility of providing psychological services (evaluation and treatment) under a rehabilitation model within public schools.

Recommendation:

Licensing requirements and services for Medicaid reimbursement could be modified to include school psychologists who are certified by the school.

This could increase the number of providers while at the same time allowing treatment services provided by school psychologists to be federally matched.

Capacity of the System

There is uncertainty as to whether or not the RSN/community-mental health system has the capacity to serve the number of children in need. Capacity takes two forms:

- A. Are there available state dollars to fund services for the children in need?
- B. Are there enough qualified practitioners who meet our standards and criteria and who are available and willing to treat Medicaid children?

Capacity is further stretched by the number of new children entering the system. There are a number of factors influencing the increase in the number of children likely to enter the system.

- A. Increase in the number of eligible children. In FY '91, a total of 295,912 children age 21 and under were eligible for Medicaid. The Medicaid population will continue to grow as each year the financial eligibility criteria of 100 percent of the Federal Poverty Level (FPL) is expanded to cover an additional year of age. Currently, children up to age six are covered up to 133 percent of FPL and children up to age 8 are covered up to 100 percent of FPL.
- B. Increase in EPSDT utilization. Currently, only 23 percent of eligible children are screened, and most of them are under age five, an age at which a mental health problem is not likely to be detected. As Medical Assistance increases the number of children screened from 23 percent to 80 percent, more mental health problems will be detected and referred for treatment.
- C. Increase in provider ability to detect potential mental illness. Medical Assistance in conjunction with MHD will be providing guidelines and assistance to providers to enable them to be more successful in assessing mental health problems in these young clients. In addition, broadening the definition of the interperiodic screen will allow EPSDT intervention anytime someone in contact with the child suspects a mental health problem.

VII. EPSDT/MENTAL HEALTH SERVICE DELIVERY PLAN

Currently, routine EPSDT screening may detect a need for a further mental health assessment. If a medical care provider suspects that a child needs mental health

treatment, the provider may suggest that the child seek mental health services, but a referral from the medical provider to the mental health system is not always made. Without the proper systems in place to facilitate referral and treatment, health care providers have not been equipped to follow through. This has allowed a growing number of children in Washington who are in need of treatment to go untreated. The following plan addresses these inadequacies.

This plan proposes a mechanism that enhances the health care giver's ability to not only refer a client for a mental assessment, but also assure that the client is evaluated and provided treatment to the extent of available resources. This strategy provides an important link between the medical and mental health treatment. In addition to receiving the physical components of an EPSDT screening and treatment, children will now be able to receive needed mental health treatment.

The structured process for accessing and delivering mental health services described below applies most directly to ongoing, planned services. Crisis service and emerging hospital care would be provided to children without going through the screening process. EPSDT screens would be arranged on an urgent basis to assure comprehensive assessment of health and mental health status. Medicaid eligible children and their families who attempted to access services on their own would be assisted in obtaining an EPSDT screening.

To address specific needs of underserved children of color, services shall be designed and developed so that they assure that minority children are able to obtain the full range of services, regardless of their ethnicity. Through systematic recognition and acknowledgement of variance in communication patterns and style, children of color shall have an improved connection with available services. RSNs will be continually obligated to select, contract and sub-contract with mental health providers who are culturally competent and experienced. RSNs shall also increase the role of minority policy makers, administrators and providers to assure affirmative action in employment.

Providers shall be contractually and otherwise encouraged to assure equal access for children and their families through affirmative outreach and community action approaches. Potential service recipients shall be provided information about available services in culturally appropriate means. Information about services and how to apply for them should be provided in the primary language of the recipient. Service plans shall reflect cultural competency and providers that are not fully culturally competent shall receive consultation and supervision from qualified staff.

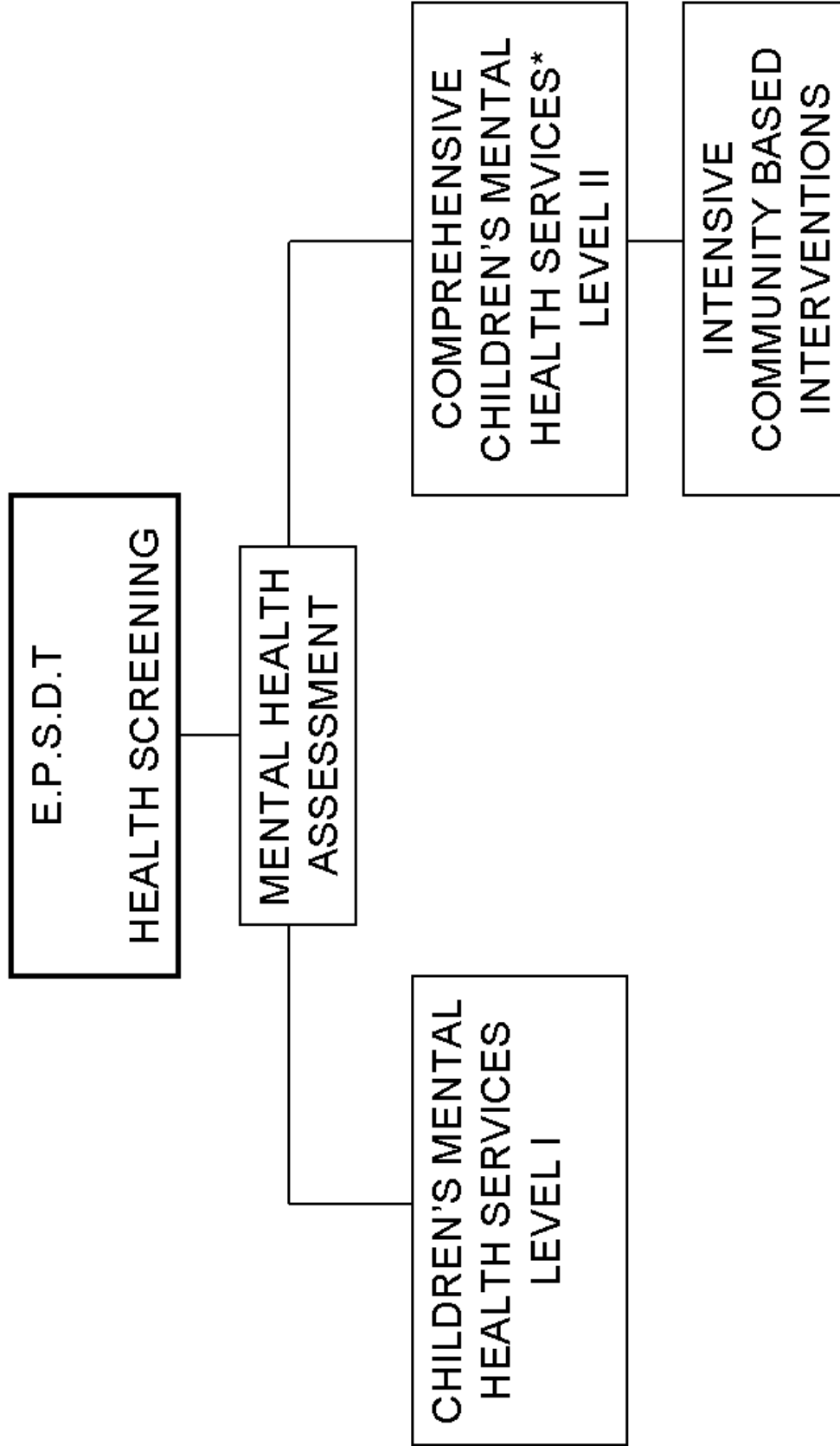
As shown in FIGURE 1, children will be screened by their health practitioner. During a routine EPSDT screening for physical disorders, the health care professional will identify those children who demonstrate behavior that might indicate an underlying mental health dysfunction. These children will be referred for a mental health assessment. In order for providers to identify possible mental health problems, health care providers

currently performing EPSDT screening will be appraised of appropriate mental health screening materials and chemical abuse indicators. Upon referral, a mental health expert selected by the RSN will then conduct an in-depth assessment of the child's mental health status. Children who have a minimal need for service will be referred to Level I services. Those children who are priority population children, in need of intensive services and involved with more than one service system, will be referred to Level II for comprehensive children's mental health services. Level II services consist of intensive community-based options, integrated across all service systems involved with the child and family. They will also be individually tailored for the specific child and family to be served. The diagram in FIGURE 2 provides a more detailed picture.

FIGURE 2 displays the proposed flow of children through the system. The following narrative corresponds to the numbers on the flow chart.

1. Medicaid-eligible children are encouraged to receive an EPSDT screen. Anyone in contact with the child or the child's family may assist the child in obtaining screening services through EPSDT.
2. Providers doing a screen identify physical and possible mental health problems, which are in need of follow-up assessment/treatment. The provider refers the child to the RSN for assessment.
- 3.a. Identified physical problems are treated.
- 3.b. After a mental health need has been identified through an EPSDT screen, an initial mental health assessment will be completed. The assessment is designed to provide a thorough picture of the child's condition (strengths and weaknesses) and determine the need for further mental health intervention. The mental health assessment shall be performed under the RSN authority, using contracted professionals if necessary.

E.P.S.D.T OVERVIEW



*Must have an interagency mechanism and a cross systems plan to participate.

A children's mental health specialist, as defined in WAC 275-56 (Appendix C), may be employed by the Regional Support Network (RSN), can provide the assessment. School psychologists, who do not currently meet federal Medicaid qualifications as mental health providers, will be included by December, 1992. This inclusion will require the state to submit an amendment to the Rehabilitation Medicaid State Plan, authorized by the Federal Health Care Financing Administration.

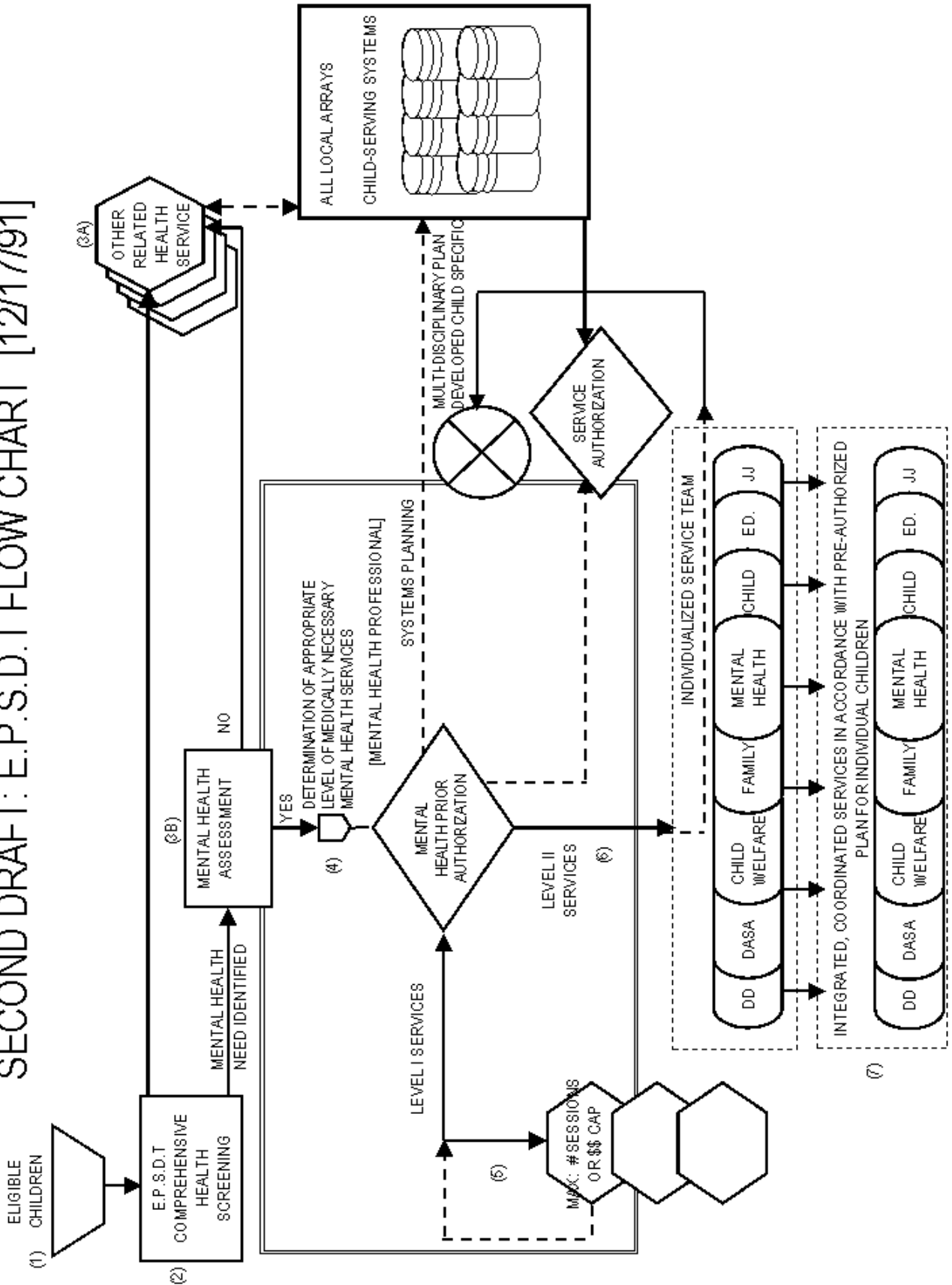
The RSNs will serve as the gatekeeper for services offered through the community mental health system. The RSNs will assure that multiple points of access are available, while integrating services to reduce duplication of effort. This means that children may be referred by community-based systems to the RSN for coordinated resulting in reduced fragmentation. As expressed in the legislative intent, coordination among child serving systems is essential to increasing efficiency, expanding access, and obtaining federal dollars for services provided. As the RSNs coordinate their mental health resources as a closely involved peer of the other child serving systems, and as EPSDT screening expand to include mental health assessments, integration of the overall mental health system will occur.

The initial assessment will consider a developmental, psycho-social and medical history of the child as well as the child's current condition. The "Environmental Matrix" and the "Determination of Functioning Adaptation Level" are examples of tools the RSNs will have the option of using as a part of the assessment. In addition, an assessment of the child's academic/learning problems and the family's needs, as well as a referral for a chemical dependency assessment, where appropriate, will be included.

Determination of a child's priority population status, as defined in RCW 71.24 as acutely mentally ill, severely emotionally disturbed, or seriously disturbed will also be made. A child/adolescent may be found to be in need of mental health services, but may not be determined to have a priority population status. These non-priority children in need of mental health intervention will also be referred for service. The mental health assessment may determine, however, that the child/adolescent has no need for additional mental health services and may be rerouted to other appropriate health services (3a).

4. Once the assessment is completed. Resource Management Services acts as the gatekeeper of the mental health system to determine and authorize the level of service each child will receive. Resource management staff, working

SECOND DRAFT: E.P.S.D.T FLOW CHART [12/17/91]



collaboratively with the child and the family and other agencies, will decide if Level I or II services would more appropriately meet the needs of the child/family. Resource management staff will have clinical training to assure appropriate assessment and admission. They will be a children's mental health specialist or be supervised by one. If there is a need to establish a wait-list for services at Level I or Level II, the RSNs will be responsible for setting the maximum allowable outer time limits, based on the type of mental health problem, and severity level of each child.

5. Level I service is defined as a short-term mental health service that will have a limit on the total costs or on the total number of visits (e.g., 10 or less). It is assumed that Level I services will be authorized for children/families with less severe need, non-priority children or perhaps a small number of priority children where a short-term intervention would appropriately address their need. If Level I services are authorized, the Resource Manager will develop the individual service plan and make a referral for treatment services.

The services provided under Level I, given our current array of Title XIX mental health services, could include individual, family, group and crisis services. Group therapy may include child social skills as well as parental training/support, promoting parental involvement in the treatment of each child. Level I services, depending on the child and family's needs could be provided by a community mental health center or a private practice children's mental health specialist.

Level I services may be provided by other appropriate child serving agencies, i.e., schools, youth service centers, etc., which provide a comparable service to the Community mental health center to meet the needs of the individual child and family. These services, however, may not all be reimbursed with medical coupons but would be considered part of the overall treatment plan. The amount of Level I services is limited. If a child and family receive the maximum number of services allowed under Level I, and there still appears to be a need for additional Level I services or multi-agency services, the service plan must be reviewed by the resource manager. Level I services may then either be re-authorized for a brief period of time, or the child and family be referred to Level II services.

6. Level II services are defined as longer term, multi-agency services to meet the complex needs of an individual child and family. It is assumed that Level II services will be authorized for children and families who have multi-system needs, such as priority population children who are high utilizers of services from multiple agencies, and Severely Emotionally Disturbed (SED) who are at risk of out-of-home placement, which, may

include children with a chronic and disabling medical condition. If Level II services are determined and authorized by the Resource Manager (RM), the child and family will be referred to an individual team established for that specific child for further evaluation and development of a cross system comprehensive service plan.

The individual team will include (as appropriate) a representative from education, child welfare, mental health, drug and alcohol, developmental disabilities, juvenile justice, and the parent or guardian of the child. Others from other systems or informal supports may be included if appropriate. The child will be included if age 13 or older; a younger child could be included if the individual service team agrees. The cross system plan must address the overall needs of the child and family, not just the Medicaid reimbursable services, and address all life areas including residential, family, social, and medical needs. The cross system will be reviewed by resource management services for mental health services and other local agencies administrators for their agencies' components and then authorized or returned for revision.

7. The mental health services provided under Level II would include the full array of Title XIX billable services (Appendix E). The individual service team would assure that the multiple needs of the individual child and family would be addressed, that services would be provided from a variety of child serving agencies appropriate to the child and family's need and coordinated in order to maximize the child's progress.

It is important to note that each team member "offers" up what his or her agency or service can provide for the child and the family so that a comprehensive treatment plan is laid out and duplications can be reduced. Sometimes a team member will participate on the team but offer nothing from his or her own system. Leadership of the treatment team and primary contact with the family will be dependent upon the person/agency most appropriate for the child and family.

While the resource manager coordinates the gathering of the team, it is also important to note that this function is not to be considered case management. The function of the team is to develop and authorize treatment plans. Federal match is available for this activity, up to 75% for the medical professionals on the team. Case management is a separate function and needs to be delegated to the appropriate system. Generally, by virtue of being a Level II child, the child and family are already involved with several systems and may already have a case manager. If more than one case manager exists, the team will assist in delegation of appropriate

roles. However, the team should not be in the role of obligating other systems financially.

The RSN will be responsible for coordinating with other community interagency councils and Family Policy Initiative activities, as appropriate, and state agencies and divisions. The integration of the treatment plan can be tied in with other plans, if appropriate and consensual, such as an Individual Education Plan (IEP) or through special education programs of the federal IDEA law 99-457's Individual Family Service Plan (IFSP). Ensuring such coordination will be a contractual requirement of the RSNs. Plans: are to be developed for the child in the context of the family. Agencies refusing to cooperate in the team risk losing federal and/or state funding.

The team will review the service plan at least semi-annually and reconfigure services as necessary. This re-evaluation may be billed a maximum of four times per 12 month period.

Although each child will be referred to either Level I or Level II services, labeling as such will not occur. To avoid confusion between Levels I and II, the parent will simply be informed of the description of services the child is able to receive.

Each local mental health authority is required to convene a collaborative multi-system group to develop a children's mental health plan in accordance with SHB 1608, Section 14. The RSNs will be responsible for determining the mental health professional to be included on the assessment team, which may include, for example, a health care professional or psychologist. Each plan will include a description of how EPSDT will be implemented in that local area. A committee of all local child serving systems will oversee initial implementation, operation and quality assurance of the local EPSDT program, including an ombudsman function. As additional services within all of the child-serving systems become Medicaid-funded, local oversight groups will play a role in determining how best to integrate these services into the community's system of care. Quality assurance is particularly needed to ensure integrity of the two levels of service.

Since this EPSDT screening and service delivery system for children and families determined to have mental health needs is a major change from most currently operating mental health service delivery systems, evaluation of the implementation of EPSDT and the various services system processes is critical. Simultaneously, a joint understanding and development of desired outcomes for children and families coupled with appropriate measures for those outcomes should be in place at the beginning of the evaluation process.

Implementation

The final consideration of the plan involves implementation. Implementation requires careful transitioning that will allow the new system to be incorporated into the current system. Since the proposed system has more structure and controls, provisions must be in place so that the new system will not be circumvented (in favor of the current less structured system) when the two systems are in place at the same time. In addition, the new system will not have the capacity to function immediately as proposed.

The implementation of the new, restructured mental health system is complex and will require both administrative and programmatic changes. To assure that EPSDT-screened children identified as having mental health problems receive some form of services in the interim, a phased implementation strategy is proposed by the Mental Health Division. This phase-in period will take several years beginning April 1, 1992, with the designation of a state level, multi-disciplinary team to set criteria for services levels and assessments. By July 1, 1993, transitioning from the current to the new system should be resolved and only one system should exist. This will need to be accomplished as a tightly managed effort. Since it is critical that the evaluation begin at the inception of the EPSDT process, by July 1, 1993, EPSDT evaluator(s) will be part of the EPSDT staff, and responsible for development and implementation of all of the evaluation processes.

PHASE ONE:

Currently, EPSDT screenings do not usually include mental health referrals. Children are generally self-referred to community mental health programs. MHD/MAA will convene a multi-disciplinary panel by April 1992, who will determine the appropriate level and amount of medically necessary services for each child using well-established criteria. The multi-disciplinary panel will be comprised of at least a child psychiatrist, child psychologist, mental health professional, school and child welfare representative. This state-level multi-disciplinary team will set criteria for service levels and assessments.

Beginning July 1, 1992. EPSDT children referred for outpatient services at community mental health programs will be given priority for evaluation and referral to appropriate services.

- Mental Health Division will revise contracts with RSNs and counties to require that children referred as a result of an EPSDT screen receive the highest priority for assessment and treatment. The Division will amend existing agreements with RSNs and counties by July 1, 1992.
- Medical Assistance Administration will develop a common referral form for use by local health departments, private practitioners, and other screening

sites to provide families with access to an evaluation by the EPSDT Resource Manager. MAA will disseminate this form to providers by July 1, 1992.

- Ongoing technical assistance/consultation and team-building training will be available at the community level starting in July, 1992.
- Also in July of 1992, explanatory materials and planning guidelines related to EPSDT will be issued to local mental health authorities and allied child-serving systems.
- Complete the exploration of the transfer of funds from MAA to MHD by August 1, 1992.
- Local plans for implementation of improved EPSDT mental health services will be submitted in accordance with SHB 1608 by October 15, 1992.

PHASE TWO:

Beginning January 1, 1993. each RSN and county will hire or designate an EPSDT Mental Health Resource Manager. They will begin taking referrals directly from EPSDT screeners for mental health assessments. These initial evaluations will provide the basis for decisions by the Resource Managers about service needs. The managers will provide or facilitate treatment planning for Level I and Level II children.

The EPSDT Mental Health Resource Managers will be designated by RSNs and counties throughout the state with placement location based on population, service needs and demand. They will conduct or arrange for initial assessments of referred children, convene the team, develop service plans and make referrals for treatment. Planning for children who are served by multiple systems and seriously emotionally disturbed will become the responsibility of the child-specific service teams.

The Resource Manager shall

- Maintain a list on file, of all EPSDT referral received;
- Establish a working relationship with an EPSDT screener to ensure timely screening of children who are identified as needing mental health services through other channels;
- Assure that each EPSDT referral receives a mental health assessment within 30 working days from the date of enrollment in the EPSDT/Children's mental health program. If circumstances occur that prevent the completion of the mental health comprehensive assessment within the 30-day limit, the

Resource Manager shall maintain a description in the clinical record of the problems encountered, the remedial actions to be taken and a specific time-line assuring completion of the comprehensive assessment;

- Assure the development of a Plan of Care for each individual referred. Where an individual's mental health needs can be met by services provided in a single agency, the agency's Treatment Plan or the Resource Manager's Service Plan shall become the Plan of Care (Level I). Where an individual's mental health needs require the services of more than one agency, the EPSDT Mental Health Resource Manager or designee will convene an Individualized Service Team to recommend a Plan of Care to the EPSDT Mental Health Resource Manager identifying necessary mental health service and appropriate service providers (Level II). The Resource Manager will sit on the team but may not necessarily direct the team, depending on the child and family's needs.
- Perform necessary administrative functions, including but not limited to:
 - a) Coordinating with EPSDT program screeners regarding the referral process; coordinate initial evaluations; reviewing services for medical necessity; developing or coordinating support services for the EPSDT referred individual and/or family; and coordinating, developing and staffing the Individual Service Team.
 - b) Assuring local community participation in the EPSDT program by providing training and consultation to early intervention services, local health, mental health, juvenile justice, education and child welfare staff regarding EPSDT services.
 - c) Assuring accessible services, resource development, data collection and maintenance of required program records.

Evaluation planning will begin on January 1, 1993, as referrals from EPSDT screeners for mental health assessments regarding level of service and treatment planning begins to come through from resource management.

PHASE THREE:

Beginning July 1, 1993, the transition phase of the current system with the merging of the new system should be complete. Self-referrals will no longer occur as all children receiving mental health treatment will be referred by the EPSDT screening process. As a result of the phase-in process, 10% of Level I children in service shall be served through child-specific teams. Increased administrative match (75%) for the authorization functions

performed by medical professionals, could be used to cover these new responsibilities. MAA will delegate authorization responsibility to the RSNs and thereby create a mental health system that is able to serve both priority (Level II) and non-priority (Level I) children.

PHASE FOUR:

By July 1, 1994, RSNs and allied child-serving systems will submit a plan and incremental time-lines leading to full implementation of the new EPSDT/mental health system.

All children receiving mental health services will be accessing them through the EPSDT screening process. This single-door coordinated approach will provide an appropriate tracking system, assure equal access, and prevent children from falling through the cracks, or getting lost in the system. At the same time, children in need of immediate access to services in a crisis situation will be able to access services quickly. Children in crisis will receive services immediately through whatever system is in contact with the child/family. If the child's problem is emergent and accesses services at the hospital, they will be referred to community mental health crisis services or committed to the hospital for inpatient services (voluntarily or involuntarily). Within the first 24 hours of hospitalization, the resource manager will be notified and begin planning with the child/family.

The education of screening providers, teachers, school nurses and counselors will be in place and ongoing, making use of appropriate assessment tools. "Child find" activities for mentally ill children will be tied in with school case find activities as much as possible.

An evaluation tool will be developed as a method of identifying deficiencies in the system. Performance indicators will be formulated to examine the measurable objectives exemplified in the referral process, quality and appropriateness of services provided, effectiveness of the multi-system team approach, and overall impact of incorporating mental health assessments with the EPSDT screening process.

VIII. COST CONTROL MECHANISMS

Although Medicaid-eligible children must receive all services deemed medically necessary to treat identified physical and mental health conditions, reasonable controls can be imposed to contain costs and direct the child to the appropriate level of service.

The range of options and how each option will be utilized in the plan are:

A. Limits on provider qualifications

Possibilities:

Medical Assistance does not have to allow every possible provider type to participate in the Medicaid program. Certain provider types are optional under Medicaid rules. Psychologists have been an optional group. The state has chosen to exclude this group from participation.

Recommendation:

Only providers who have a demonstrated expertise in children's mental health and who meet the definition of mental health professional will be utilized. Psychiatrists are categorized as physicians and physician services are a mandated coverage under Title XIX, so psychiatrists will continue to be used.

Currently, independently practicing psychologists cannot be reimbursed for treatment services. MAA is presently working with the provider association to review this policy and will amend its state plan by January 1, 1993 to include licensed psychologists as providers for assessments and Level I services for children.

Level I children will be able to choose an independent practicing mental health provider who is on contract with the RSN. Level II children will be directed to providers deemed qualified to deliver Level II services.

In addition, the Level II providers will have performance-based contracts.

B. Service Limits

Possibilities:

Guidelines can be set on the amount of money per client or on the number of services per client that can be provided without authorization. These limits cannot be implemented without justification and a provision for prior authorization if medical necessity for services still remains after the limit is used up.

Recommendation:

It is recommended that initially, Level I children receive ten visits. Additional needs must be reviewed and a maximum of ten more visits could be

authorized if the prognosis supports further Level I services. Otherwise, the child then receives Level II services. Service limits for Level II children would be determined by the Individualized Service Team.

C. Prior Authorization

Possibilities:

Providers can be required to get authorization prior to service delivery. The authorizing entity reviews the request for medical necessity and appropriateness. Questionable service or unusual durations may require justification prior to extensions beyond an initial period of service. Patients can be directed to "less costly, equally effective" levels of service.

Recommendation:

As described above, use service limitation on Level I and prior authorization controls for services beyond initial ten visits. All Level II services must be approved prior to service delivery in order to be a part of the comprehensive plan. The RSN resource management will provide the authorization function and determine which level is appropriate for the child, whether services be extended, and will review treatment plans. The RSN resource manager will authorize treatment plans for the Level II children recommended by the Individualized Service Team.

D. Utilization Review

Possibilities:

Provider records and/or billing records can be reviewed both before and/or after payment. Should a provider seem to be exceeding a reasonable service package, a more in-depth review can take place to make sure the service is warranted.

Recommendation:

The Medicaid Medical Management Information System (MMIS) will be used for payment so unusual practice patterns can be identified. However, because the RSNs will be authorizing all service, post utilization review will not be as important. Prior authorization controls are sufficient.

E. Managed Care

Possibilities:

A manager of the recipient's care places the referral and authorization function with a provider who coordinates all care for the individual recipient. A recipient might be able to receive a wide range of services but only if seen as appropriate for the recipient and/or cost-effective. A care manager also looks at the sequence of services provided so as to receive maximum medical benefit.

Recommendation:

It is not recommended that the managed care option per se be used in the mental health plan. Although the care will be "managed" by the resource manager, the care will not have to be provided by one provider as is traditionally used in managed care plans. This allows for more flexible and appropriate services, and encourages more providers to become qualified as a children's mental health provider.

F. Capitated Payment

Possibilities:

A premium is paid for all services received in a month, regardless of utilization. If more services are used than the premium covers, the provider absorbs the expense. But if the care is less than the expected average cost, the provider is able to build up the pool to hedge against high utilizers, or even to save money. Costs can be controlled within the length of the contract.

Recommendation:

It is not recommended that mental health payments be capitated at this time. Not enough data is available on the types of care and expenditures for children's mental health services to set a reasonable average payment. There could be problems with "creaming" clients and quality of care issues with this option.

G. Diagnostic Related Group (DRG) Payment for Hospital-Based Inpatient Services

Possibilities:

Payment can be set by diagnosis, regardless of type(s) of service provided, based on an average cost for that diagnosis. If it costs less than the average DRG to achieve the desired patient outcome, than the provider retains the money to offset times when a patient with that diagnosis costs more than the DRG.

Recommendation:

It is recommended that DRGs continue to be used with certain inpatient mental health services for children. Long-term inpatient treatment is currently reimbursed on a cost-based reimbursement methodology. Continued experience with the costs of long-term hospitalization may warrant such a cost control in the future but not enough utilization and expenditure data is currently available.

H. Reimbursement Level

Possibilities:

The rate of Medicaid reimbursement will affect the size of the provider pool, which again can effectively become a cost control mechanism if not many providers wish to participate.

Recommendation: Current reimbursement levels Will be used.

Tracking Mental Health Referrals

The method to be employed for tracking mental health referrals will be the billing process. Currently, statistics on utilization of EPSDT are obtained from billing information. When a provider bills for an EPSDT service, specific information is required such as the age of the child and identification of the services that were rendered. Other pertinent information obtained from the billing form is used to determine demographic and utilization data throughout the state. Similarly, with a mental health screening, information submitted by the provider on the billing form can be used to track which clients have been referred for assessment and treatment. In addition, RSNs/counties will be required to report on:

- The number of unduplicated children referred;
- The level of service to which they are categorized;
- Types of service required (both fee-for-service mental health and mental health-related service provided through the schools, etc.);
- Utilization; and
- Expenditures associated with each child.

IX. ENSURING FEDERAL MEDICAID MATCHING FUNDS

Over the past several years the department has been working to ensure that Medicaid matching funds are obtained. The department has made great strides in identifying matchable services and setting procedures in place to claim match.

- A. RSNs and community mental health systems are identifying their Medicaid eligible clients and billing Medicaid for services. Of 10,500 children served by the mental health network in 1990, approximately 9,400 were Medicaid-eligible children.
- B. Case management services to high risk Child Protective Services (CPS) children, foster children and certain special needs children receive Title XIX match.
- C. The Department of Social and Health Services plans to submit a state plan amendment to allow it to claim therapeutic childcare and Homebuilders as a matched service. The amendment is awaiting federal approval. Further work administratively and with providers remains to determine if match will be obtained.
- D. The mental health system recently converted to a "rehabilitative service" mode of delivery care, thus obtaining match for services perilously unmatched. This was completed by July 1, 1991.
- E. Through the SHB 2014 project, psychologist and other services provided in schools to special needs children are obtaining match in some school districts. Eighty of the 297 school districts are in the process of implementation, only nine are billing for services.
- F. Match is being obtained for personal care services for certain foster children needing a higher degree of care due to medical necessity.

However, there are still areas in which there is opportunity for match. In implementing this plan, the department will focus on:

- A. Identifying areas in which administrative activities can receive matching funds. Under this approach, salaries of people performing duties in support of the administration of the Title XIX State Plan can be matched. This might include people in the RSN who do assessments and prior authorization, members of the collaborative interagency team determine the best mix of service for the child, and school and interagency/program personnel who work with the child. It is important to note that administrative expenses will not be covered with service dollars.

It is expected that 75% federal match can be obtained for assessments and authorizations, if performed by a physician or nurse practitioner. Fifty percent match could be obtained for those performed by providers of other disciplines. The state match would have to come from new or existing resources; new resources being the preferred option so that current service levels would not have to be reduced.

- B. Identifying which services in the array of services available to children through inter/intra agency collaboration can be matched.

It is unknown now how much additional match is to be obtained through these explorations.

Issues to consider as match is pursued include:

- A. If a service is provided free to other children, as in a school setting, Medicaid cannot be billed for the service. Special education services are exempt from this provision. However, if other third party insurers are contributing towards the cost of the service, then the service is not considered free. Many insurers consider educational services a public responsibility and contend that their liability does not extend to such services.
- B. Confidentiality issues may constrict some of the efforts to identify Medicaid eligibility and thus claim Federal Financial Participation (FFP). Medical assistance status is not known unless the parent or child is asked, or unless eligibility information is obtained from the department.
- C. FFP is available at a larger match (75 percent) for certain administrative functions, such as prior authorization activities conducted by skilled medical personnel. If the RSN and other entities are willing and able to hire and assign the appropriately skilled and licensed personnel to these activities, we will be able to realize greater match.
- D. In some instances, services not currently matched could obtain match if the service provider adapted to Medicaid rules and criteria. But because this may involve additional paperwork, increased documentation, and

impact workloads, service quality and availability may be adversely effected to an unacceptable extent.

- E. In order to receive FFP, providers have to meet Medicaid qualifications. In some situations, potential areas for match are not currently provided by providers meeting these guidelines. Using providers who meet Medicaid's requirements may increase costs substantially. In some areas of the state, qualified providers may' not be available.
- F. Medicaid services must be medically necessary_and provided to individual clients. These rules preclude most preventive and educational services, such as classes on stress or group meetings educating about child abuse, from being matched.
- G. Because Medicaid is an entitlement program, if the service is offered to one client, the service will generally have to be offered to all covered clients, including adults. EPSDT affords an opportunity to target certain services to just children. However, all clients are required to go through an EPSDT exam in order to obtain services included in the state plan. This plan proposes that an EPSDT screen be required in order to access mental health services. The emergent nature of some of the services precludes obtaining the exam in some cases. Requiring children to go through a screen could be speeded up, if children's mental health providers have their own medical EPSDT screeners but this compromises the idea of one "medical home" implicit in EPSDT. That is, the screener should be the ongoing and treating provider as much as possible, in order to detect other developing problems. The administrative burden to providers may be a deterrent to serving Medicaid eligible children.

Some potential program areas for claiming match, given the above-mentioned limitations are listed below. While the budget of the entire program usually is not eligible for match, the counseling or other mental health services involved might be eligible for match. However, it must be cautioned that resolving the Medicaid issues in these programs may involve restructuring the programs, which may alter the intent of the program. Also, the administrative costs such as billing all clients and hiring qualified providers, may outweigh the amount of match obtained.

Potential Matchable Services

Potential Barriers to Matching

- | | |
|---|---|
| 1. DJR Group Home Therapy | Client eligibility, qualifications of providers |
| 2. DJR Diagnostic Services | Same as above |
| 3. DCFS Psychological and Psychiatric Services | Some providers and services may not meet Medicaid requirements. |
| 4. DCFS Early Identification Therapy for Sexually Abused Kids | Non-Medicaid clients need to be billed; unlikely most providers meet Medicaid's qualifications. |
| 5. DCFS Therapeutic Child Care | Many of the providers do not meet Medicaid's requirements: non-Medicaid clients need to be billed, but parents may not participate if billed. Some federal funds are already being claimed. |
| 6. DCFS Homebuilders | Significant provider contractual changes are required that may jeopardize participation. |
| 7. DCFS Family Reconciliation | Non-Medicaid clients need to be billed; qualified providers need to be used. |
| 8. Department of the Blind. Child and Family Program | Most of the services are not medically necessary; qualified providers would be needed; non-Medicaid clients need to be billed. |
| 9. Labor and Industries Crime Victims | Qualified providers needed who accept Medicaid. |
| 10. OSPI Substance Abuse | Services need to be client-specific; medically necessary; qualified providers need to be used; non-Medicaid clients need to be billed. |
| 11. OSPI Education for Homeless Children | Same as above. |
| 12. OSPI Fairstart | Same as above. |
| 13. Mental Health Division Primary Intervention Program | Medical necessity, qualified providers need to be used. non-Program Medicaid clients need to be billed. |

Some of the programs, which clearly do not meet Medicaid guidelines, due to such factors as provider qualifications or eligibility of clients, are included in the list that follows:

Non-Matchable Programs

Prohibiting Factor

- | | |
|---|--|
| 1. DJR Institutional Care | Is not a Medicaid service, and Medicaid clients are not served. |
| 2. Parole Services | Is not a Medicaid service. |
| 3. DCFS Child Protective Services/Child Welfare Service | With the exception of certain case management functions, these are not Medicaid services. |
| 4. Division of Developmental Disabilities Family Support | Is not a Medicaid service. |
| 5. Department of Corrections | Is not covered by Medicaid. |
| 6. Department of Health Nursing Visits | Usually don't involve medical necessary services-they are generally preventive, not treatment. |
| 7. Birth to Six Planning Project | Federally funded; not medically necessary services. |
| 8. Washington Council for the Prevention of Child Abuse & Neglect | Educational and awareness activities not covered by Medicaid. |
| 9. OSPI Alcohol Awareness Programs | Educational, not covered by Medicaid. |
| 10. OSPI Child Abuse Prevention | Educational, not covered by Medicaid. |
| 11. OSPI Student Retention | Educational, not covered by Medicaid. |
| 12. OSPI Substance Abuse Programs | Educational, not covered by Medicaid |

Other DSHS programs serving children such as the Division of Mental Health and the Division of Alcohol and Substance Abuse are already receiving Medicaid match.

X. APPENDICES

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APPENDIX A

MEDICAL ELIGIBILITY FOR CHILDREN

September 17, 1990

CURRENT ELIGIBILITY

CATEGORICALLY NEEDY ELIGIBILITY

The "H" Categorically Needy medical program is a federal program for children born after September 30, 1983, up to eight years of age. There is no limit on resources for these children.

Children under 1

Group 1

The child is automatically eligible if:

1. The child remains in the home of the mother.
2. The mother received Medicaid at the time of birth.
3. The mother remains eligible for Medicaid.

Group 2

1. Income is under 185% of the Federal Poverty Level (FPL).
2. Meets citizenship, enumeration and residency requirements

Children one year of age but under six

1. Income is under 133% of the FPL
2. Meets citizenship, enumeration and residency requirements.

Children age six but under eight (born on or after 10/1/83)

1. Income is under 100% of the FPL
2. Meets citizenship, enumeration and residency requirements.

MEDICALLY NEEDED ELIGIBILITY

Children who, except for income, would be eligible as Categorically Needy under the H medical program may be eligible as Medically Needy under the "H" medical program. There is a \$2000 resource limit for these children.

Under the Medically Needy program, medical bills must be incurred which equal the amount of excess income before medical coverage can be authorized. This process is called spenddown.

SCOPE OF CARE

Full scope of medical care is available to children eligible for either the Categorically Needy program or the Medically Needy program.

ADDITIONAL ELIGIBILITY GROUPS EFFECTIVE JANUARY 1 1991

CATEGORICALLY NEEDED ELIGIBILITY

Children age seven (born before 10/1/83) but under eighteen

The federal "H" Categorically Needy medical program is being expanded to include children eight years of age (born before October 1, 1983) up to 18 years of age.

1. Resources are limited to \$1000.
2. Income is under the AFDC grant standard.
3. Meets citizenship, residency and enumeration requirements.

MEDICALLY NEEDED ELIGIBILITY

The federal "H" Medically Needy program is being expanded to include children eight years of age (born before October 1, 1983) up to 18 years of age, who, except for income, would be eligible as Categorically Needy under the "H" medical program. There is a \$2000 resource limit for these children.

Under the Medically Needy program, medical bills must be incurred which equal the amount of excess income before medical coverage can be authorized. This process is called spenddown.

CHILDREN'S HEALTH PROGRAM ELIGIBILITY

Children from birth to eighteen years of age

The new state funded "V" medical program (Children's Health Program) includes children from birth up to 18 years of age who are not eligible for a federal medical program.

1. Resources are not limited.
2. Income is under 100% of the FPL.
3. Meets residency requirements.
4. Neither citizenship nor enumeration is required.

SCOPE OF CARE

Full scope medical care is available for children eligible for either the Categorically Needy program, the Medically Needy program or the state funded 'V' medical program (Children's Health Program).

APPENDIX B

Washington State EPSDT Utilization By Age of Recipient
Calendar Year 1990

	TOTAL EPSDT ELIGIBLE	TOTAL EPSDT USERS	% EPSDT USERS
AGE			
0...	23,226	12,476	53.7
1...	25,348	13,689	54.0
2...	22,092	7,705	34.9
3...	20,191	4,392	21.8
4...	18,978	5,552	29.3
5...	18,543	5,482	29.6
6...	16,738	2,646	15.8
7...	14,994	1,521	10.1
8...	14,342	1,299	9.1
9...	13,591	1,214	8.9
10...	12,838	1,083	8.4
11...	11,622	1,019	8.8
12...	10,304	1,123	10.9
13...	9,955	1,263	12.7
14...	9,238	1,242	13.4
15...	9,183	1,105	12.0
16...	9,024	1,013	11.2
17...	8,931	968	10.8
18...	9,251	1,028	11.1
19...	8,462	1,256	14.8
20...	9,460	1,393	14.7
TOTAL...	296,311	68,469	

NOTE: During Calendar Year 1990, 23.1% at all statewide eligible persons utilized EPSDT services.

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APPENDIX D

Definitions of Mental Health Professionals

WAC 275-56-185 PERSONNEL MANAGEMENT--QUALIFICATIONS APPROPRIATE TO THE NEEDS OF THE CONSUMER POPULATION

The provider shall ensure that the clinical qualifications of person providing and/or supervising direct treatment services reflect the needs of the consumer population.

- (1) Services directed to children shall be provided by, under the supervision of, or with consultation from a child mental health specialist defined as follows:
 - (a) A mental health professional having completed a minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the study of child development and the treatment of seriously disturbed children and their families: and
 - (b) Having the equivalent of one year of full-time experience in the treatment of seriously disturbed children and their families under the supervision of child mental health specialist.

*MENTAL HEALTH PROFESSIONAL means:

- (a) A physician or osteopath licensed under chapter 18.57 or 18.71 RCW, who is board eligible in psychiatry;
- (b) A psychologist licensed under Chapter 18.83 RCW;
- (c) A psychiatric nurse, which means a registered nurse licensed under Chapter 18.88 RCW and having at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional;
- (d) A social worker, which means a person with a masters or further advanced degree from an accredited school of social work or a degree from a graduate school deemed equivalent by the secretary;
- (e) A person having at least a masters degree in behavioral sciences, nursing sciences, or related field from an accredited college or university and having

at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional;

- (f) A mental health counselor or marriage and family therapist certified under Chapter 18.19 RCW and having at least two years' experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional;
- (g) A professionally licensed occupational or physical therapist having at least two years experience in the direct treatment of mentally ill individuals under the supervision of a mental health professional; or
- (h) A person having at least a bachelors degree in behavioral sciences or related field from an accredited college or university and having at least five years experience in the direct treatment of mentally ill individuals under the supervision of mental health professionals.

APPENDIX E

~~TITLE XIX SERVICE MODALITIES REHABILITATION OPTION~~

~~(Effective July 1, 1994 Amended 2003)~~

GENERAL PROVISIONS:

~~Note: The location of these services may occur either in-facility or out-of-facility (except for stabilization services, which are delivered only out-of-facility). Differing rates will be reflected for in-facility and out-of-facility services, when it is appropriate.~~

~~1. Crisis Services:~~

~~"Crisis Services" means face-to-face evaluation and treatment of mental health emergencies and crises to non-enrolled as well as enrolled, individuals experiencing a crisis as defined by the WAC. Crisis services shall be available on a 24-hour basis with the goal of stabilizing the person in crisis and providing immediate or short-term treatment and support in the least restrictive environment available. Crisis services may be provided prior to an intake evaluation.~~

~~2. Stabilization Services:~~

~~"Stabilization Services" means services provided to persons who are experiencing a mental health emergency or crisis. This service is to be provided in the person's own home or another home-like setting. Stabilization services shall include short term (less than two weeks per episode) face-to-face assistance with self care meals, and medication monitoring. Stabilization services may be provided prior to an intake evaluation.~~

~~3. Intake Evaluation:~~

~~"Intake Evaluation" means an evaluation initiated prior to the provision of any other services, except crisis services and stabilization services. The intake evaluation must establish the medical necessity for treatment and be completed within thirty days.~~

4. ~~Special Population Evaluation:~~

~~"Special Population Evaluation" means an evaluation by a specialist as defined by the WAC, which considers age and cultural variables specific to the individual being evaluated, and other culturally and age consistent evaluation methods. This evaluation shall provide information relevant to consumer's continuation in appropriate treatment and assist in treatment planning. Consultation from a on-staff specialist may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.~~

5. ~~Interdisciplinary Evaluation for Nursing Home Resident:~~

~~"Interdisciplinary Evaluation for Nursing Home Resident" means a comprehensive intake/evaluation for an eligible Title XIX nursing home resident requiring mental health treatment. The evaluation must be ordered by the attending physician and conducted by a mental health professional in collaboration with nursing home staff, a minority specialist when appropriate; the attending physician (optional); and a psychiatrist, if available. When evaluating consumers over the age of 60, the mental health professional shall be a geriatric mental health specialist. A face-to-face contact/interview with the nursing home resident, relevant collateral contacts (including nursing home staff), and a review of the nursing home chart are required. A listing of professionals who participated in the evaluation and a joint recommendation for meeting the needs of the individual must be recorded in the consumer's health record in the nursing home and in the CMHC consumer record. This service shall last a minimum of one hour. The service shall also meet the criteria of an intake/evaluation as defined in the WAC and be initiated prior to any other services except crisis services or stabilization services. This evaluation shall be completed within thirty (30) days.~~

6. ~~Psychological Assessment:~~

~~"Psychological Assessment" means all psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.~~

7. ~~Medication Management:~~

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

8. ~~Individual Treatment Services:~~

~~"Individual Treatment Services" means a set of face-to-face treatment activities designed to help the consumer attain goals as prescribed in the consumer's individual treatment plan. These services shall be congruent with the age and cultural framework of the individual and may be conducted with the consumer, his or her family, or others who play a necessary role in assisting the consumer to maintain stability in living, work or educational environments. These services may include, but are not limited to: developing the consumer's independent self care skills; monitoring and supervising of the consumer's functioning; health services; counseling and psychotherapy. This service does not include consultation with other mental health staff from the same agency.~~

9. ~~Group Treatment Services:~~

~~"Group Treatment Services" means a set of face-to-face activities provided by one or more staff to two or more consumers which are designed to help the consumer attain goals as prescribed in the consumer(s) individual treatment plan. These activities shall be consistent with the age and cultural framework of the individual and may be conducted with groups of consumers, families, or others who play a necessary role in assisting the consumer(s) to maintain stability in living, work or educational environments. These services may include, but are not limited to: developing the consumer's independent self care skills; monitoring and supervising the consumer's functioning; health services; counseling and psychotherapy. This service does not include consultation with other mental health staff from the same agency.~~

10. ~~Adult Day Treatment~~

~~"Adult Day Treatment" means a program intended to provide a range and mix of planned and structured services to mentally ill persons 18 years of age and older. These services are designed to:~~

- ~~(a) maintain consumers in an environment less restrictive than an inpatient setting through structuring of day and leisure time;~~
- ~~(b) develop and maintain necessary community living and self care skills, such as: education in health and nutritional issues, personal maintenance, money management, and maintaining the living environment; developing basic language skills necessary to enable the consumer to function independently; training in appropriate use of community services; prevocational services and treatment approaches congruent with the age and cultural framework of the individual.~~

~~11. Adult Acute Diversion Services:~~

~~"Adult Acute Diversion Services" means a separate and distinct program for non-enrolled as well as enrolled individuals which is a less restrictive alternative to inpatient hospitalization, or is a transitional program after discharge from inpatient services. This service is designed for persons with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. The minimum staff to patient ratio for this service is 1:4. This service includes a mix of individual, group services and crisis services. This service may be provided up to six (6) hours per day for up to thirty (30) days per consumer per year. Extensions must be authorized by the Mental Health Division. Only intake evaluation, medication management, psychological assessment, and special population evaluation modalities may be billed separately from this modality on the same day.~~

~~12. Children and Adolescent Day Treatment:~~

~~"Child and Adolescent Day Treatment" means a program intended to provide a range and mix of planned and structured services to disturbed persons under the age of 18, unless a written authorization for exception is granted by the mental health division. These services are designed to:~~

- ~~(a) Maintain consumers in their community, in an environment less restrictive than an inpatient or residential setting through structuring of day and leisure time;~~
- ~~(b) develop age appropriate daily living, educational and social skills to maximize the growth and developmental potential of each consumer;~~
- ~~(c) serve as an alternative to more restrictive long-term inpatient or residential care.~~

~~13. Child and Adolescent Acute Diversion Services:~~

~~"Acute Diversion Services for Children and Adolescents" means a program of intensive, short-term, mental health services for non-enrolled as well as enrolled acutely mentally ill youth at immediate risk of receiving care in an inpatient unit. Services shall include an age appropriate mix of services which include social/recreational activities. Reimbursement identified for this modality shall include all services provided, with the exception of intake, medication management, special population evaluation, and psychological assessment. The minimum staff to consumer ratio shall be one clinical staff member for every three consumers).~~

~~This program of services is designed to:~~

- ~~(a) stabilize the crisis situation and maintain the consumer in the most normative, least restrictive environment possible;~~
- ~~(b) provide an immediate assessment of treatment needs and develop an individualized treatment and discharge plan;~~
- ~~(c) begin rebuilding developmental deficits, responding to the youth's social, emotional, and education needs;~~
- ~~(d) develop and implement an after care plan.~~

APPENDIX F

MEDICAID REIMBURSEMENT TO SCHOOLS

SUMMARY OF CLAIMS SUBMITTED THROUGH OCTOBER 1991

DISTRICTS*	BILLED	PAID
Adna	\$ 177.86	\$ 87.91
Castle Rock	1,147.70	557.78
Chehalis	3,415.35	1,460.36
ESD 112	3,482.13	1,506.48
Longview	176.34	77.97
Moses Lake	12,013.07	6,905.32
Ocean Beach	6,288.88	2,542.83
Vancouver	44.19	33.49
White Pass	1,365.10	994.80
TOTAL	\$28,110.62	\$14,166.94

* "Districts" may contain more than one school district.

APPENDIX G

Definition and Eligibility Criteria for Seriously Behaviorally Disabled

WAC 392-171-386 Definition and eligibility criteria for seriously behaviorally disabled. (1) Seriously behaviorally disabled students are those who exhibit one or more of the following characteristics over a long period of time and to a marked degree which adversely affects their own educational performance:

- (a) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
- (b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- (c) Inappropriate types of behavior or feelings under normal circumstances;
- (d) A general pervasive mood of unhappiness or depression; or
- (e) A tendency to develop physical symptoms or fears associated with personal or school problems.

(2) The term includes students who are schizophrenic. The term include students who socially maladjusted, unless it is determined that they are also seriously behaviorally disabled. Students whose primary disability is identified in another handicapping category do not qualify as seriously behaviorally disabled.

(3) All students considered for initial placement in special education as seriously behaviorally disabled shall be assessed by a multidisciplinary team including at least one school psychologist or school social worker and determined as eligible for special education and related services according to the following:

- (a) A current school district evaluation which concludes that the student has a serious behavioral disability and which considers and describes the student's social and emotional behaviors and provides any implications for educational planning.
- (b) For the purposes of establishing that the student has a behavioral disability, the evaluation shall describe behaviors, which distinguish between common disciplinary problem behaviors and serious behavioral disabilities. Common disciplinary problem behaviors (e.g., truancy, smoking, breaking school conduct rules) may exist in conjunction with serious behavioral disabilities, but cannot be used as the sole criteria for recommending special education and related services.

The evaluation shall include:

- (i) Dated and signed documented anecdotal records of

behavioral observations made by two or more persons at separate times and places, each of which cite and corroborate specific behaviors which, in the aggregate, provide foundation for probable concern for serious behavioral disability. Multiple settings are required (e.g., in addition to the classroom setting consider playground, cafeteria, school bus, hallway, etc.); and

- (ii) Dated and signed documented evidence of at least two intervention techniques that have been tried and the effect of each. These interventions may include, but are not limited to, changes in student's regular class schedule, curriculum, and/or teacher, school counseling, community agency therapy, or counseling, and
- (iii) A social or developmental history compiled directly from the parent(s) and/or records, when parents are not available.

(c) Current assessment of level of academic or cognitive achievement as measured by standardized tests appropriate to age level and administered individually.

(d) A current vision and hearing screening report.

(e) In the event that the required academic assessment and vision and hearing screening are completed and there are documented and dated anecdotal records of behavioral observations showing that the student's disability is evident in the school environment, the following evaluation reports may be substituted for the school's district's evaluation:

(i) A current psychiatric evaluation, which considers and describes the student's social and emotional behaviors, which concludes and describes a serious behavioral disability and where implications for educational planning are provided. The multidisciplinary team shall consider these implications in planning and implementing the student's educational program;

or

(ii) A current psychological evaluation by a nonpublic school mental health professional who holds a graduate degree in a recognized mental health specialty that considers and describes the student's social and emotional behaviors, which concludes that the student has a serious behavioral disability, the consequences of which entail the necessity for active, on-going therapy and/or counseling, and where implications for educational planning are provided. The multidisciplinary team shall consider these implications in planning and implementing the student's educational program. [Statutory Authority: RCW

34.05.220 [(1)] (a). 89-23-001 (Order 15), § 392-171-386, filed 11/2/89, effective 12/3/89. Statutory Authority: RCW 28A.13.070(7), 84-14-036 (Order 84-19), § 392-171-386, filed 6/28/84; 83-08-029 (Order 83-1), § 392-171-386, filed 3/30/83; 80-11-054 (Order 80-31), § 392-171-386, filed 8/19/80.]

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