Appendix E

Projected Cost of House Bill 1088 – Revised

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July 24, 2009

Sue Breen
Chief of Mental Health Finance
Division of Rates and Finance
Health and Recovery Services Administration
P.O. Box 45320
Olympia, WA 98504-5320

Re: Projected Cost of House Bill 1088 -- Revised

Dear Sue,

Per your request, we have estimated the projected cost of enhancing children's Medicaid mental health services along the lines proposed by the Mental Health Division (hereafter "Division"), pursuant to requirements in House Bill 1088. Specifically, we have estimated the costs of two approaches to complying with House Bill 1088:

- Section 4 (1) – Revision to Access to Care Standards. The Division has proposed to meet the goals of this section (earlier identification, brief intervention, etc.) by relaxing the Access to Care Standard (ACS), under two separate scenarios. Note that an easing of the standard is accomplished by raising the current Children's Global Assessment Scale (CGAS) score threshold. For example, under the current standard, full access to the Regional Support Network (RSN) modalities is allowed when a client's level of mental health functioning is 50 or less.[1] By raising the standard it is assumed that a new cohort of clients will gain access to the system.
- Section 4 (2) – Revised Children's Mental Health Benefit Package. The Division has asked us to project the cost of implementing several modalities which would meet the goals of this paragraph, namely: increasing the use of certain high-intensity programs (wraparound services, multidimensional foster care services (MTFC), multisystemic therapy (MST)), and to provide for subacute residential crisis respite services.

We have attached a copy of House Bill 1088 for information purposes (Attachment A).

Please note that this projection, as will be discussed below, has relied on the validity of several assumptions that are not easily verified. Chief among them is the degree to which CGAS scores are currently being applied in a consistent and unbiased manner. We recommend that the Mental

[1] Note that clients with a CGAS score from 50-60, while authorized to receive a limited scope of services, are likewise authorized to access the full scope based on "clinical assessment, medical necessity and need."

Health Division consider the findings of this report in light of other, non-actuarial perspectives on the effects of raising the ACS thresholds.

Revision to Access to Care Standards — Findings and Discussion

The current Access to Care Standard (Attachment B) stipulates that children can gain access to RSN mental health services under two "Levels:"

> 1) Brief Intervention, which generally allows for a shorter authorization period and a limited range of modalities, (except in cases where clinical assessment, medical necessity or need require access to the full scope), and
>
> 2) Community Support, which authorizes a longer period of treatment and the full range of State Plan modalities.

In order to qualify for Level 1, children must score 60 or below on a CGAS evaluation; to qualify for Level 2, they must score 50 or below on the CGAS score. Further, children age 0-5 are not required to meet the CGAS criteria to be eligible for care.

Our examination of the data largely confirms adherence to the above model:

- Aside from Pierce and North Central, 95% of Medicaid children using the RSN system ages 6-17 have CGAS scores assigned to them in the encounter database. In many cases, scores are recorded either quarterly or even monthly.
- Pierce and North Central have largely *not* assigned CGAS scores, or have not uploaded these scores to the State's encounter database. We understand that Pierce RSN ceased to operate 1/1/08 (i.e., the middle of the experience period considered in this study). However, it is also true that CGAS scores were largely unreported as far back as October 2006.
- Children 18 and above, while paid for under a "child rate" are not, as we understand it, considered children for purposes of ACS, and hence have a far lower frequency of CGAS scores assigned.
- Children below the age of 6 rarely have CGAS scores. This is consistent with the exemption stipulated by the ACS guidelines.
- Some RSNs assign precise scores, in increments of 1, whereas a significant number of RSNs report CGAS scores rounded to the nearest 10. This seems to support anecdotal evidence that the CGAS scoring is subjective and approximate.
- Although participation in the RSN program drops sharply for clients with a CGAS score above 60, a material portion of the RSNs' eligibles have CGAS scores 60 and above. It is not clear why clients with such scores are receiving care. Discussion with staff indicates that these scores may reflect individuals whose functional impairment has decreased in the course of treatment. Note, however that the data does not support this hypothesis,

insofar as there are not many cases of clients entering the program at a much lower score and experiencing higher scores at the conclusion of their authorization period. We would recommend that the division review utilization for clients with high CGAS scores for compliance with the ACS.

- The CGAS scores for the overwhelming majority of children remain constant throughout their participation in the program. Scores generally do not improve, nor deteriorate.
- The OP encounter data are not able to distinguish between Level 1 and Level 2 participants. Rather, individuals in both Levels seem to receive all services.
- The OP encounter data indicate that costs to treat clients decrease significantly as CGAS scores increase. At the highest scores, monthly costs are generally equivalent to the cost of 1-2 counseling sessions.

Table 1 below shows the percentage increase in Medicaid costs, as well as a round-number estimate of the increase, in FY2009 funding, to implement the increases envisioned by House Bill 1088. Note that we have subdivided our estimate between the various elements and options, and have also provided optimistic and pessimistic scenarios from a cost perspective.

Table 1
Projected Cost Increases for Revisions to Access-to-Care Standard

ACS Revision Scenario	*Forecast*	*Percent*	*Additional Annual Funding*
Raise CGAS Thresholds by 5 Points to 55/65	Pessimistic	16%	$17,600,000
Raise CGAS Thresholds by 5 Points to 55/65	Optimistic	6%	$6,600,000
Raise CGAS Thresholds by 10 Points to 60/70	Pessimistic	24%	$26,400,000
Raise CGAS Thresholds by 10 Points to 60/70	Optimistic	9%	$9,900,000

In order to calculate the estimated required funding for House Bill 1088's program enhancements, we have assumed a baseline total FY2008 capitation revenue for children to RSNs of $110 million. It is important to understand that the Division is considering a substantial

rebasing of rates. If such a rebasing results in significant changes to the projected cost of children's mental health services, this analysis may need revision.

The following exhibits provide background information and calculations for the figures in Table 1:

- Exhibit 1: Estimated Costs Under Current ACS Standard
- Exhibit 2: Cost of Raising CGAS threshold to 55/65 – Pessimistic Scenario
- Exhibit 3: Cost of Raising CGAS threshold to 60/70 – Pessimistic Scenario
- Exhibit 4: Cost of Raising CGAS threshold to 55/65 – Optimistic Scenario
- Exhibit 5: Cost of Raising CGAS threshold to 60/70 – Optimistic Scenario

In addition to examining the data sources, we have also brought to bear our experience with the Washington State mental health program. In our conversations with RSN and Division staff, we understand that there is a widespread recognition that the ACS standard is not necessarily applied consistently from RSN to RSN. In addition, there is widespread variation in services, utilization trends and costs from RSN to RSN, and from year to year. In considering a model which projects costs under a revised ACS standard, we have created a pessimistic scenario, which assumes higher penetration and utilization, as well as a more optimistic scenario, which assumes a lesser increase in penetration and utilization.

Below are several concepts which seem to support assumptions behind the Pessimistic Forecast:

- Not only will new clients gain access to the RSN system, but Medicaid providers who refer clients to the RSNs will do so more liberally. As a result, not only will more individuals with marginal CGAS scores (50-70) gain access, but even some patients with scores less than 50 will gain access.
- Expansion of the program at the same time as an economic downturn, and the closing of other agencies' programs, could significantly increase demand for RSN services.

These considerations support the adoption of an Optimistic Forecast:

- CGAS scores are widely recognized to be subjective; it is possible that clinicians who evaluate clients are able to manage entrance to the program by under- or over-scoring. Hence, under this understanding, it is possible that changes in the CGAS threshold will not have a large impact on the number of children seeking services.
- For children who currently do not meet the ACS standard, but receive services on a Medicaid FFS basis, it is possible that RSN services will increase, but will be offset by reductions in Healthy Options rates, to the extent that Healthy Options rates are adjusted to reflect marginally lower demand for mental health services provided as a component

of the physical program. To the extent that children have historically received mental health services in the FFS system, there will likewise be reductions in FFS costs.

- Individuals with CGAS scores that are too high for inclusion in the current program may, without access, deteriorate to the point where crisis or other RSN intervention is necessary in any event. Under this understanding, it is possible that children who eventually gain access will simply do so earlier.
- Inclusion of relatively low-need clients in the program may have lower marginal costs than the current program participants. In other words, it is possible to view the RSN system as having excess capacity to be able to handle, without substantial extra funding, additional low-need clients who require occasional counseling, etc.

As stated earlier, we recommend that the Mental Health Division consider the above findings in light of other information available.

Discussion and Methodology

To perform this projection, we first requested a complete data set of outpatient encounters from the Mental Health Division. Before analyzing this data, we performed the following adjustments:

- Calculation of Age: We applied an "age at date of service" to every encounter and considered services only for individuals less than 22 years of age.
- Assignment of RSN was based on the RSN which recorded the majority of the care to a client.
- Modality and Pricing: For purposes of analyzing cost differentials by CGAS score, we applied unit cost assumptions consistent with the last actuarial study (adjusted for trend) with several simplifying assumptions. In total, we believe these costs are reasonably consistent with current capitation rates.
- While we did not attempt to perform a comprehensive rate study, our review of the data reinforced observations from earlier actuarial reviews: utilization and penetration vary widely by RSN.
- Observing that Pierce and North Central did not contribute CGAS scores to the encounter database, we excluded these RSNs from the data. We did extrapolate our findings to include Pierce and North Central in our annual cost estimates.

After applying the above adjustments we summarized the number of unique users, user months, cost per user month, average months per user, and PEPM costs, as shown in Exhibit 1. We also assumed trended inpatient costs of $2.13 PEPM, and RSN administration of approximately 12.5% of revenue in the computation of the expected annual cost.

In order to project utilization and costs for the various scenarios, we adjusted current penetration and average user months as follows:

Table 2
Application of Projection Assumptions

CGAS Range		Pessimistic Scenario: Raise CGAS Threshold by 5	Pessimistic Scenario: Raise CGAS Threshold by 10	Optimistic Scenario: Raise CGAS Threshold by 5	Optimistic Scenario: Raise CGAS Threshold by 10
20-29	Users	No Change		No Change	
	Avg Months	No Change		No Change	
30-39	Users	No Change		No Change	
	Avg Months	No Change		No Change	
40-49	Users	Increase by 5%		No Change	
	Avg Months	No Change	No Change	No Change	
50-59	Users	Increase by 10%		Increase by 5%	
	Avg Months	Increase by 3%	Increase by 3%	No Change	
60-64	Users	Increase by 50% of 50-59		Increase by 25% of 50-59	
	Avg Months	Increase by 11%	Increase by 20%	Increase by 2%	Increase by 11%
65-69	Users	Increase by 50% of 60-64	Increase by 50% of 50-59	Increase by 25% of 60-64	Increase by 25% of 50-59
	Avg Months	Increase by 83%	Increase by 100%	Increase by 17%	Increase by 33%
70+	Users	Increase by 50% of 60-64	Increase by 75% of 60-64	Increase by 10% of 60-64	Increase by 25% of 60-64
	Avg Months	Increase by 122%	Increase by 150%	Increase by 11%	Increase by 39%

Note that the largest technical challenge with this projection is estimating the CGAS distribution of those clients which are not currently gaining access to the RSN system, as well as their potential referral to, and participation, in the program. Lacking any data sources for this, we have assumed that the number of people accessing the system in any given CGAS category will be equal to the current number plus some portion of the clients in the cohorts with lower CGAS scores.

In a revision of the program with the scope envisioned by House Bill 1088, there are a large variety of factors that are not possible to accurately forecast, but which could materially impact the cost of the revision:

- Impacts on State-only funding; e.g. the tendency of the expansion of one program (Medicaid) to have shadow effects on similarly placed programs, or for services for new entrants which are not Medicaid-reimbursable.
- Heightened or dampened prescription drug utilization due to greater contact with RSN system.
- Cost offsets in other programs. To the extent that early identification and effective treatment of mental health clients succeeds in meeting the outcome-based performance measures (see Section 3 [2]), there could be material savings in RSN, Medicaid, other State and local agencies.
- We believe that implementation of revised ACS standards will require time to "phase in," as providers and stakeholders in the RSN system become aware of increased access. We have not attempted to project the speed at which the system would reach a new equilibrium.
- Changes to RSN administrative costs that differ from assumptions.
- We have not considered the degree to which cost increases would be offset or shared by increases in local match funding or revised (federal stimulus) federal matching amounts.

Revised Children's Mental Health Benefit Package — Findings and Discussion

The Division has proposed to meet the goals of Section 4 (2) by implementing four new modalities:

Wraparound service coordination. This modality serves to better coordinate existing services, and is not a treatment in and of itself. In research provided by TriWest Group to the Division[2], TriWest estimated that this program, implemented over time, would serve over 4,000 children, with a gross cost of approximately $800 per person served per month. This leads to a projected annual cost of nearly $38 million per year. While we believe TriWest's analysis is reasonable, it is clear that this forecast is dependent on a large number of assumptions. For example, the estimate of users (0.56% of Medicaid-enrolled children) was based on similar programs in two higher-cost RSNs: Greater Columbia and King RSNs. It is possible that demand in rural RSNs will be much smaller. Likewise, TriWest emphasizes that there is considerable uncertainty surrounding the value of cost offsets. Finally, it seems to us that the cost of this program, using the assumptions identified by TriWest, is unreasonably high ($38 million, or nearly a third of current funding, to treat a small cohort of the population). It is likely that cost and/or demand assumptions have been overstated. Rather than rely on pro-forma forecasts, we would

[2] See "Statewide Transformation Initiative – Mental Health Benefit Package Design Final Report", TriWest Group, July 2007.

recommend that the Division study the costs and benefits of this program on a pilot basis, and to reach out to RSN coordinators for an estimate of potential demand for the program.

Multidimensional Treatment Foster Care (MTFC). Our understanding is that this modality, when performed at a "fidelity" level, requires a 10-bed program which is intended to provide care to youth who are either in foster care, or who are preparing to reunite with their families. Consequently, it is not only more expensive, but contains elements which are not reimbursable by federal match funding. Furthermore, the estimate provided by TriWest emphasizes uncertainty in demand, offsets, the allocation of costs between TXIX and State-only funding, and is further complicated by the degree to which facilities for this modality are co-located with the Children's Administration. Although TriWest forecasts an ultimate mid-range cost of $9.2 million (to treat an average of 135 clients per month, or approximately 13.5 10-bed programs across the State)[3], it is possible that the demand and cost for this modality should likewise be discussed with RSN and provider staff for more accurate cost estimates.

Multisystemic Therapy, according to the TriWest report, is an "evidence-based practice with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency." The report also emphasizes that this modality can operate under a variety of case loads, frequency and intensity, but did not venture a cost projection. Because this modality is also operated by schools as well as the juvenile justice system, it seems likely that demand for this service would vary sharply by RSN and even by client, and could be provided under a variety of cost assumptions. Hence, we are not able to provide an accurate forecast.

Subacute Residential Crisis Respite Services. Our understanding is that this modality would provide bed days, perhaps in existing residential facilities, for runaway children, or children in crisis, to stay pending reunification with families. This modality is, like several of the modalities previously discussed, potentially co-located with the juvenile justice system and includes cost elements not matched by Title XIX funding.

We regret that in the above cases we have been unable to provide defined cost projections. We hope that our discussion of each modality illustrates the factors that complicate an accurate forecast. We believe a more accurate method of forecasting costs for programs of this nature would be to either run pilot programs, or to survey demand based on more detailed conversations with RSN staff. The factors that make specialized programs feasible for certain populations are not uniform across the State, making local staff the more suitable stakeholders for estimation of program costs.

Caveats

The information contained in this letter, including the enclosures, has been prepared for the State of Washington Department of Social and Health Services (DSHS) and their consultants and

[3] See pages vii and viii of Statewide Transformation Initiative – Mental Health Benefit Package Design Final Report, by Triwest Group, July, 2007.

advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for DSHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions.

This analysis has relied extensively on data provided by DSHS. While we have performed numerous checks of reasonableness and have made adjustments where necessary, we have not performed an independent audit of the data. Errors in data reporting may flow through the analysis, and as such would impact the results.

Actual results will vary from our projections for many reasons, including differences from assumptions regarding provider negotiated discounts, the degree of health care management, macro-economic factors and their affects on caseloads, and the effects of other program changes, as well as other random and non-random factors.

Sincerely,

Steve Knowlton, ASA, MAAA
Associate Actuary

/par
Attachments

cc: Tim Barclay, Milliman
Thuy Hua-Ly, HRSA
MaryAnne Lindeblad, HRSA

Washington State Mental Health Division
HB 1088
Projection of Costs for Relaxed ACS Threshold

Projection Period: FY2008 (July 2007 – June 2008) *Age 0-20 Average Eligible Months* 568,301
Exhibit 1

Estimated Distribution of Care by Age and CGAS Under Current ACS Standards

		Aged 6-17								
	Aged 0-5	*CGAS 0-29*	*CGAS 30-39*	*CGAS 40-49*	*CGAS 50-59*	*CGAS 60-64*	*CGAS 65-69*	*CGAS 70+*	*Aged 18-20*	*Total*
Annual Users	3,530	1,664	1,173	10,408	14,185	2,090	305	445	3,326	37,124
Annual User Months	18,431	4,334	8,999	70,443	89,532	11,374	910	820	14,461	219,303
Months per User	5.2	2.6	7.7	6.8	6.3	5.4	3.0	1.8	4.3	5.9
Contribution to Penetration Rate	0.6%	0.3%	0.2%	1.8%	2.5%	0.4%	0.1%	0.1%	0.6%	6.5%
Raw Cost Per User Per Month	$307.07	$326.22	$535.43	$369.33	$273.07	$201.06	$171.62	$144.35	$351.41	$319.19
Contribution to PMPM, Outpatient Services	$0.83	$0.21	$0.71	$3.81	$3.59	$0.34	$0.02	$0.02	$0.75	**$10.26**
Estimated IP PMPM										$2.13
Estimated RSNAdmin PMPM										$1.38
Estimated Total PMPM, IP and OP										$13.77

Washington State Mental Health Division
HB 1088
Projection of Costs for Relaxed ACS Threshold

Projection Period: FY2008 (July 2007 – June 2008)
Exhibit 2

Age 0-20 Average Eligible Months 568,301

Projected Distribution of Care by Age and CGAS Under Scenario 1 (Raise CGAS by 5 Points), Pessimistic Scenario

		Aged 6-17								
	Aged 0-5	*CGAS 0-29*	*CGAS 30-39*	*CGAS 40-49*	*CGAS 50-59*	*CGAS 60-64*	*CGAS 65-69*	*CGAS 70+*	*Aged 18-20*	*Total*
Annual Users	3,530	1,664	1,173	**10,928**	**15,603**	**9,182**	**1,349**	**1,489**	3,326	48,245
Annual User Months	18,431	4,334	8,999	73,965	101,419	55,091	7,422	5,958	14,461	290,079
Months per User	5.2	2.6	7.7	6.8	**6.5**	**6.0**	**5.5**	**4.0**	4.3	6.0
Contribution to Penetration Rate	0.6%	0.3%	0.2%	1.9%	2.7%	1.6%	0.2%	0.3%	0.6%	8.5%
Raw Cost Per User Per Month	$307.07	$326.22	$535.43	$369.33	$273.07	$201.06	$171.62	$144.35	$351.41	$293.70
Contribution to PMPM, Outpatient Services	$0.83	$0.21	$0.71	$4.01	$4.06	$1.62	$0.19	$0.13	$0.75	**$12.49**
Estimated IP PMPM										$2.13
Estimated RSNAdmin PMPM										$1.38
Estimated Total PMPM, IP and OP										$16.00
Percent Increase										16%

Washington State Mental Health Division
HB 1088
Projection of Costs for Relaxed ACS Threshold

Projection Period: FY2008 (July 2007 – June 2008)
Exhibit 3

Age 0-20 Average Eligible Months 568,301

Projected Distribution of Care by Age and CGAS Under Scenario 1 (Raise CGAS by 10 Points), Pessimistic Scenario

		Aged 6-17								
	Aged 0-5	*CGAS 0-29*	*CGAS 30-39*	*CGAS 40-49*	*CGAS 50-59*	*CGAS 60-64*	*CGAS 65-69*	*CGAS 70+*	*Aged 18-20*	*Total*
Annual Users	3,530	1,664	1,173	**10,928**	**15,603**	**9,182**	**7,397**	**2,012**	3,326	54,815
Annual User Months	18,431	4,334	8,999	73,965	101,419	59,682	44,381	9,053	14,461	334,725
Months per User	5.2	2.6	7.7	6.8	**6.5**	**6.5**	**6.0**	**4.5**	4.3	6.1
Contribution to Penetration Rate	0.6%	0.3%	0.2%	1.9%	2.7%	1.6%	1.3%	0.4%	0.6%	9.6%
Raw Cost Per User Per Month	$307.07	$326.22	$535.43	$369.33	$273.07	$201.06	$171.62	$144.35	$351.41	$277.57
Contribution to PMPM, Outpatient Services	$0.83	$0.21	$0.71	$4.01	$4.06	$1.76	$1.12	$0.19	$0.75	**$13.62**
Estimated IP PMPM										$2.13
Estimated RSNAdmin PMPM										$1.38
Estimated Total PMPM, IP and OP										$17.13
Percent Increase										24%

Washington State Mental Health Division
HB 1088
Projection of Costs for Relaxed ACS Threshold

Projection Period: FY2008 (July 2007 – June 2008)
Exhibit 4

Age 0-20 Average Eligible Months 568,301

Projected Distribution of Care by Age and CGAS Under Scenario 1 (Raise CGAS by 5 Points), Optimistic Scenario

		Aged 6-17								
	Aged 0-5	*CGAS 0-29*	*CGAS 30-39*	*CGAS 40-49*	*CGAS 50-59*	*CGAS 60-64*	*CGAS 65-69*	*CGAS 70+*	*Aged 18-20*	*Total*
Annual Users	3,530	1,664	1,173	10,408	**14,894**	**5,636**	**827**	**654**	3,326	42,111
Annual User Months	18,431	4,334	8,999	70,443	94,009	30,996	2,894	1,307	14,461	245,874
Months per User	5.2	2.6	7.7	6.8	6.3	**5.5**	**3.5**	**2.0**	4.3	5.8
Contribution to Penetration Rate	0.6%	0.3%	0.2%	1.8%	2.6%	1.0%	0.1%	0.1%	0.6%	7.4%
Raw Cost Per User Per Month	$307.07	$326.22	$535.43	$369.33	$273.07	$201.06	$171.62	$144.35	$351.41	$307.39
Contribution to PMPM, Outpatient Services	$0.83	$0.21	$0.71	$3.81	$3.76	$0.91	$0.07	$0.03	$0.75	**$11.08**
Estimated IP PMPM										$2.13
Estimated RSNAdmin PMPM										$1.38
Estimated Total PMPM, IP and OP										$14.59
Percent Increase										6%

Washington State Mental Health Division
HB 1088
Projection of Costs for Relaxed ACS Threshold

Projection Period: FY2008 (July 2007 – June 2008)
Exhibit 5

Age 0-20 Average Eligible Months 568,301

Projected Distribution of Care by Age and CGAS Under Scenario 1 (Raise CGAS by 10 Points), Optimistic Scenario

		Aged 6-17								
	Aged 0-5	*CGAS 0-29*	*CGAS 30-39*	*CGAS 40-49*	*CGAS 50-59*	*CGAS 60-64*	*CGAS 65-69*	*CGAS 70+*	*Aged 18-20*	*Total*
Annual Users	3,530	1,664	1,173	10,408	**14,894**	**5,636**	**3,851**	**967**	3,326	45,448
Annual User Months	18,431	4,334	8,999	70,443	94,009	33,814	15,403	2,418	14,461	262,311
Months per User	5.2	2.6	7.7	6.8	6.3	**6.0**	**4.0**	**2.5**	4.3	5.8
Contribution to Penetration Rate	0.6%	0.3%	0.2%	1.8%	2.6%	1.0%	0.7%	0.2%	0.6%	8.0%
Raw Cost Per User Per Month	$307.07	$326.22	$535.43	$369.33	$273.07	$201.06	$171.62	$144.35	$351.41	$299.08
Contribution to PMPM, Outpatient Services	$0.83	$0.21	$0.71	$3.81	$3.76	$1.00	$0.39	$0.05	$0.75	**$11.50**
Estimated IP PMPM										$2.13
Estimated RSNAdmin PMPM										$1.38
Estimated Total PMPM, IP and OP										$15.01
Percent Increase										9%

Attachment A

CERTIFICATION OF ENROLLMENT

SECOND SUBSTITUTE HOUSE BILL 1088

60th Legislature
2007 Regular Session

Passed by the House April 19, 2007
Yeas 94 Nays 4

Speaker of the House of Representatives

Passed by the Senate April 19, 2007
Yeas 39 Nays 10

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE HOUSE BILL 1088** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

Secretary of State
State of Washington

SECOND SUBSTITUTE HOUSE BILL 1088

AS AMENDED BY THE SENATE

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Dickerson, Kagi, Haler, Cody, Appleton, Darneille, Simpson, Takko, Kenney, Williams, Green, McDermott, Roberts, Lantz, McCoy, Ormsby, Schual-Berke, B. Sullivan, Hurst, Pettigrew, O'Brien, Lovick, P. Sullivan, Hasegawa, Hunt, Hudgins, Clibborn, Upthegrove, Morrell, Conway, Sells, Haigh, Quall, Moeller, Goodman, Wallace, Wood and Santos)

READ FIRST TIME 03/05/07.

AN ACT Relating to children's mental health services; amending RCW 71.36.005 and 71.36.010; adding new sections to chapter 71.36 RCW; adding new sections to chapter 74.09 RCW; adding a new section to chapter 71.24 RCW; creating new sections; repealing RCW 71.36.020 and 71.36.030; and providing expiration dates.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 71.36.005 and 1991 c 326 s 11 are each amended to read as follows:

The legislature intends to ((~~encourage the development of community-based interagency collaborative efforts to plan for and provide mental health services to children in a manner that~~)) <u>substantially improve the delivery of children's mental health services in Washington state through the development and implementation of a children's mental health system that:</u>

<u>(1) Values early identification, intervention, and prevention;</u>

<u>(2) C</u>oordinates existing categorical children's mental health programs and funding, <u>through efforts that include elimination of duplicative care plans and case management;</u>

(3) Treats each child in the context of his or her family, and provides services and supports needed to maintain a child with his or her family and community;

(4) Integrates families into treatment through choice of treatment, participation in treatment, and provision of peer support;

(5) Focuses on resiliency and recovery;

(6) Relies to a greater extent on evidence-based practices;

(7) Is sensitive to the unique cultural circumstances of children of color((~~, eliminates duplicative case management,~~)) and children in families whose primary language is not English;

(8) Integrates educational support services that address students' diverse learning styles; and

(9) To the greatest extent possible, blends categorical funding to offer more service and support options to each child.

Sec. 2. RCW 71.36.010 and 1991 c 326 s 12 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Agency" means a state, tribal, or local governmental entity or a private not-for-profit organization.

(2) "Child" means a person under eighteen years of age, except as expressly provided otherwise in state or federal law.

(3) "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

(4) "County authority" means the board of county commissioners or county executive.

((~~(4)~~)) (5) "Department" means the department of social and health services.

((~~(5)~~)) (6) "Early periodic screening, diagnosis, and treatment" means the component of the federal medicaid program established pursuant to 42 U.S.C. Sec. 1396d(r), as amended.

((~~(6)~~)) (7) "Evidence-based" means a program or practice that has had multiple site random controlled trials across heterogeneous

populations demonstrating that the program or practice is effective for the population.

(8) "Family" means a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the department of social and health services, or a tribe.

(9) "Promising practice" or "emerging best practice" means a practice that presents, based upon preliminary information, potential for becoming a research-based or consensus-based practice.

(10) "Regional support network" means a county authority or group of county authorities or other nonprofit entity that ((~~have~~)) has entered into contracts with the secretary pursuant to chapter 71.24 RCW.

((~~(7)~~)) (11) "Research-based" means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.

(12) "Secretary" means the secretary of social and health services.

(13) "Wraparound process" means a family driven planning process designed to address the needs of children and youth by the formation of a team that empowers families to make key decisions regarding the care of the child or youth in partnership with professionals and the family's natural community supports. The team produces a community-based and culturally competent intervention plan which identifies the strengths and needs of the child or youth and family and defines goals that the team collaborates on achieving with respect for the unique cultural values of the family. The "wraparound process" shall emphasize principles of persistence and outcome-based measurements of success.

NEW SECTION. **Sec. 3.** A new section is added to chapter 71.36 RCW to read as follows:

ELEMENTS OF A CHILDREN'S MENTAL HEALTH SYSTEM. (1) It is the goal of the legislature that, by 2012, the children's mental health system in Washington state include the following elements:

(a) A continuum of services from early identification, intervention, and prevention through crisis intervention and inpatient treatment, including peer support and parent mentoring services;

(b) Equity in access to services for similarly situated children, including children with co-occurring disorders;

(c) Developmentally appropriate, high quality, and culturally competent services available statewide;

(d) Treatment of each child in the context of his or her family and other persons that are a source of support and stability in his or her life;

(e) A sufficient supply of qualified and culturally competent children's mental health providers;

(f) Use of developmentally appropriate evidence-based and research-based practices;

(g) Integrated and flexible services to meet the needs of children who, due to mental illness or emotional or behavioral disturbance, are at risk of out-of-home placement or involved with multiple child-serving systems.

(2) The effectiveness of the children's mental health system shall be determined through the use of outcome-based performance measures. The department and the evidence-based practice institute established in section 7 of this act, in consultation with parents, caregivers, youth, regional support networks, mental health services providers, health plans, primary care providers, tribes, and others, shall develop outcome-based performance measures such as:

(a) Decreased emergency room utilization;

(b) Decreased psychiatric hospitalization;

(c) Lessening of symptoms, as measured by commonly used assessment tools;

(d) Decreased out-of-home placement, including residential, group, and foster care, and increased stability of such placements, when necessary;

(e) Decreased runaways from home or residential placements;

(f) Decreased rates of chemical dependency;

(g) Decreased involvement with the juvenile justice system;

(h) Improved school attendance and performance;

(i) Reductions in school or child care suspensions or expulsions;

(j) Reductions in use of prescribed medication where cognitive behavioral therapies are indicated;

(k) Improved rates of high school graduation and employment; and

(l) Decreased use of mental health services upon reaching adulthood for mental disorders other than those that require ongoing treatment to maintain stability.

Performance measure reporting for children's mental health services should be integrated into existing performance measurement and reporting systems developed and implemented under chapter 71.24 RCW.

NEW SECTION. **Sec. 4.** REGIONAL SUPPORT NETWORK SERVICES--CHILDREN'S ACCESS TO CARE STANDARDS AND BENEFIT PACKAGE. As part of the system transformation initiative, the department of social and health services shall undertake the following activities related specifically to children's mental health services:

(1) The development of recommended revisions to the access to care standards for children. The recommended revisions shall reflect the policies and principles set out in RCW 71.36.005, 71.36.010, and section 3 of this act, and recognize that early identification, intervention and prevention services, and brief intervention services may be provided outside of the regional support network system. Revised access to care standards shall assess a child's need for mental health services based upon the child's diagnosis and its negative impact upon his or her persistent impaired functioning in family, school, or the community, and should not solely condition the receipt of services upon a determination that a child is engaged in high risk behavior or is in imminent need of hospitalization or out-of-home placement. Assessment and diagnosis for children under five years of age shall be determined using a nationally accepted assessment tool designed specifically for children of that age. The recommendations shall also address whether amendments to RCW 71.24.025 (26) and (27) and 71.24.035(5) are necessary to implement revised access to care standards;

(2) Development of a revised children's mental health benefit package. The department shall ensure that services included in the children's mental health benefit package reflect the policies and principles included in RCW 71.36.005 and section 3 of this act, to the extent allowable under medicaid, Title XIX of the federal social security act. Strong consideration shall be given to developmentally appropriate evidence-based and research-based practices, family-based interventions, the use of natural and peer supports, and community

support services. This effort shall include a review of other states' efforts to fund family-centered children's mental health services through their medicaid programs;

(3) Consistent with the timeline developed for the system transformation initiative, recommendations for revisions to the children's access to care standards and the children's mental health services benefits package shall be presented to the legislature by January 1, 2009.

NEW SECTION. **Sec. 5.** A new section is added to chapter 74.09 RCW to read as follows:

IMPROVING MEDICATION MANAGEMENT AND CARE COORDINATION. (1)(a) The department, in consultation with the evidence-based practice institute established in section 7 of this act, shall develop and implement policies to improve prescribing practices for treatment of emotional or behavioral disturbances in children, improve the quality of children's mental health therapy through increased use of evidence-based and research-based practices and reduced variation in practice, improve communication and care coordination between primary care and mental health providers, and prioritize care in the family home or care which integrates the family where out-of-home placement is required.

(b) The department shall identify those children with emotional or behavioral disturbances who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers, and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(c) The department shall review the psychotropic medications of all children under five and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(d) The department shall track prescriptive practices with respect to psychotropic medications with the goal of reducing the use of medication.

(e) The department shall encourage the use of cognitive behavioral

therapies and other treatments which are empirically supported or evidence-based, in addition to or in the place of prescription medication where appropriate.

(2) The department shall convene a representative group of regional support networks, community mental health centers, and managed health care systems contracting with the department under RCW 74.09.522 to:

(a) Establish mechanisms and develop contract language that ensures increased coordination of and access to medicaid mental health benefits available to children and their families, including ensuring access to services that are identified as a result of a developmental screen administered through early periodic screening, diagnosis, and treatment;

(b) Define managed health care system and regional support network contractual performance standards that track access to and utilization of services; and

(c) Set standards for reducing the number of children that are prescribed antipsychotic drugs and receive no outpatient mental health services with their medication.

(3) The department shall submit a report on progress and any findings under this section to the legislature by January 1, 2009.

NEW SECTION. **Sec. 6.** A new section is added to chapter 71.36 RCW to read as follows:

MEDICAID ELIGIBLE CHILDREN IN TEMPORARY JUVENILE DETENTION. The department shall explore the feasibility of obtaining a medicaid state plan amendment to allow the state to receive medicaid matching funds for health services provided to medicaid enrolled youth who are temporarily placed in a juvenile detention facility. Temporary placement shall be defined as until adjudication or up to sixty continuous days, whichever occurs first.

NEW SECTION. **Sec. 7.** A new section is added to chapter 71.24 RCW to read as follows:

CHILDREN'S MENTAL HEALTH PROVIDERS. (1) The department shall provide flexibility in provider contracting to regional support networks for children's mental health services. Beginning with 2007-2009 biennium contracts, regional support network contracts shall authorize regional support networks to allow and encourage licensed

community mental health centers to subcontract with individual licensed mental health professionals when necessary to meet the need for an adequate, culturally competent, and qualified children's mental health provider network.

(2) To the extent that funds are specifically appropriated for this purpose or that nonstate funds are available, a children's mental health evidence-based practice institute shall be established at the University of Washington division of public behavioral health and justice policy. The institute shall closely collaborate with entities currently engaged in evaluating and promoting the use of evidence-based, research-based, promising, or consensus-based practices in children's mental health treatment, including but not limited to the University of Washington department of psychiatry and behavioral sciences, children's hospital and regional medical center, the University of Washington school of nursing, the University of Washington school of social work, and the Washington state institute for public policy. To ensure that funds appropriated are used to the greatest extent possible for their intended purpose, the University of Washington's indirect costs of administration shall not exceed ten percent of appropriated funding. The institute shall:

(a) Improve the implementation of evidence-based and research-based practices by providing sustained and effective training and consultation to licensed children's mental health providers and child-serving agencies who are implementing evidence-based or researched-based practices for treatment of children's emotional or behavioral disorders, or who are interested in adapting these practices to better serve ethnically or culturally diverse children. Efforts under this subsection should include a focus on appropriate oversight of implementation of evidence-based practices to ensure fidelity to these practices and thereby achieve positive outcomes;

(b) Continue the successful implementation of the "partnerships for success" model by consulting with communities so they may select, implement, and continually evaluate the success of evidence-based practices that are relevant to the needs of children, youth, and families in their community;

(c) Partner with youth, family members, family advocacy, and culturally competent provider organizations to develop a series of

information sessions, literature, and on-line resources for families to become informed and engaged in evidence-based and research-based practices;

(d) Participate in the identification of outcome-based performance measures under section 3(2) of this act and partner in a statewide effort to implement statewide outcomes monitoring and quality improvement processes; and

(e) Serve as a statewide resource to the department and other entities on child and adolescent evidence-based, research-based, promising, or consensus-based practices for children's mental health treatment, maintaining a working knowledge through ongoing review of academic and professional literature, and knowledge of other evidence-based practice implementation efforts in Washington and other states.

(3) To the extent that funds are specifically appropriated for this purpose, the department in collaboration with the evidence-based practice institute shall implement a pilot program to support primary care providers in the assessment and provision of appropriate diagnosis and treatment of children with mental and behavioral health disorders and track outcomes of this program. The program shall be designed to promote more accurate diagnoses and treatment through timely case consultation between primary care providers and child psychiatric specialists, and focused educational learning collaboratives with primary care providers.

NEW SECTION. **Sec. 8.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The department shall adopt rules and policies providing that when youth who were enrolled in a medical assistance program immediately prior to confinement are released from confinement, their medical assistance coverage will be fully reinstated on the day of their release, subject to any expedited review of their continued eligibility for medical assistance coverage that is required under federal or state law.

(2) The department, in collaboration with county juvenile court administrators and regional support networks, shall establish procedures for coordination between department field offices, juvenile rehabilitation administration institutions, and county juvenile courts that result in prompt reinstatement of eligibility and speedy

eligibility determinations for youth who are likely to be eligible for medical assistance services upon release from confinement. Procedures developed under this subsection must address:

(a) Mechanisms for receiving medical assistance services' applications on behalf of confined youth in anticipation of their release from confinement;

(b) Expeditious review of applications filed by or on behalf of confined youth and, to the extent practicable, completion of the review before the youth is released; and

(c) Mechanisms for providing medical assistance services' identity cards to youth eligible for medical assistance services immediately upon their release from confinement.

(3) For purposes of this section, "confined" or "confinement" means detained in a facility operated by or under contract with the department of social and health services, juvenile rehabilitation administration, or detained in a juvenile detention facility operated under chapter 13.04 RCW.

(4) The department shall adopt standardized statewide screening and application practices and forms designed to facilitate the application of a confined youth who is likely to be eligible for a medical assistance program.

NEW SECTION. **Sec. 9.** Educational service district boards may partner with regional support networks to respond to a request for proposal for operation of a wraparound model site under this act and, if selected, may contract for the provision of services to coordinate care and facilitate the delivery of services and other supports under a wraparound model.

NEW SECTION. **Sec. 10.** WRAPAROUND MODEL OF INTEGRATED CHILDREN'S MENTAL HEALTH SERVICES DELIVERY. To the extent funds are specifically appropriated for this purpose, the department of social and health services shall contract for implementation of a wraparound model of integrated children's mental health services delivery in up to four regional support network regions in Washington state in which wraparound programs are not currently operating, and in up to two regional support network regions in which wraparound programs are

currently operating. Contracts in regions with existing wraparound programs shall be for the purpose of expanding the number of children served.

(1) Funding provided may be expended for: Costs associated with a request for proposal and contracting process; administrative costs associated with successful bidders' operation of the wraparound model; the evaluation under subsection (5) of this section; and funding for services needed by children enrolled in wraparound model sites that are not otherwise covered under existing state programs. The services provided through the wraparound model sites shall include, but not be limited to, services covered under the medicaid program. The department shall maximize the use of medicaid and other existing state-funded programs as a funding source. However, state funds provided may be used to develop a broader service package to meet needs identified in a child's care plan. Amounts provided shall supplement, and not supplant, state, local, or other funding for services that a child being served through a wraparound site would otherwise be eligible to receive.

(2) The wraparound model sites shall serve children with serious emotional or behavioral disturbances who are at high risk of residential or correctional placement or psychiatric hospitalization, and who have been referred for services from the department, a county juvenile court, a tribal court, a school, or a licensed mental health provider or agency.

(3) Through a request for proposal process, the department shall contract, with regional support networks, alone or in partnership with either educational service districts or entities licensed to provide mental health services to children with serious emotional or behavioral disturbances, to operate the wraparound model sites. The contractor shall provide care coordination and facilitate the delivery of services and other supports to families using a strength-based, highly individualized wraparound process. The request for proposal shall require that:

(a) The regional support network agree to use its medicaid revenues to fund services included in the existing regional support network's benefit package that a medicaid-eligible child participating in the wraparound model site is determined to need;

(b) The contractor provide evidence of commitments from at least the following entities to participate in wraparound care plan development and service provision when appropriate: Community mental health agencies, schools, the department of social and health services children's administration, juvenile courts, the department of social and health services juvenile rehabilitation administration, and managed health care systems contracting with the department under RCW 74.09.522; and

(c) The contractor will operate the wraparound model site in a manner that maintains fidelity to the wraparound process as defined in RCW 71.36.010.

(4) Contracts for operation of the wraparound model sites shall be executed on or before April 1, 2008, with enrollment and service delivery beginning on or before July 1, 2008.

(5) The evidence-based practice institute established in section 7 of this act shall evaluate the wraparound model sites, measuring outcomes for children served. Outcomes measured shall include, but are not limited to: Decreased out-of-home placement, including residential, group, and foster care, and increased stability of such placements, school attendance, school performance, recidivism, emergency room utilization, involvement with the juvenile justice system, decreased use of psychotropic medication, and decreased hospitalization.

(6) The evidence-based practice institute shall provide a report and recommendations to the appropriate committees of the legislature by December 1, 2010.

NEW SECTION. **Sec. 11.** A new section is added to chapter 74.09 RCW to read as follows:

(1) To the extent that funds are specifically appropriated for this purpose the department shall revise its medicaid healthy options managed care and fee-for-service program standards under medicaid, Title XIX of the federal social security act to improve access to mental health services for children who do not meet the regional support network access to care standards. Effective July 1, 2008, the program standards shall be revised to allow outpatient therapy services to be provided by licensed mental health professionals, as defined in

RCW 71.34.020, and up to twenty outpatient therapy hours per calendar year, including family therapy visits integral to a child's treatment.

(2) This section expires July 1, 2010.

NEW SECTION. **Sec. 12.** (1) The evidence-based practice institute established in section 7 of this act, in consultation with the Washington state institute for public policy, shall review and summarize current law with respect to inpatient and outpatient mental health treatment for minors.

(2) The review shall include current practices to determine the percentage of cases in which parents are engaged by treatment providers and the extent to which they are actively involved in the treatment of their minor children.

(3) The evidence-based practice institute shall provide a report and recommendations to the appropriate legislative committees by December 1, 2008.

(4) This section expires December 1, 2008.

NEW SECTION. **Sec. 13.** The following acts or parts of acts are each repealed:

(1) RCW 71.36.020 (Plan for early periodic screening, diagnosis, and treatment services) and 2003 c 281 s 4 & 1991 c 326 s 13; and

(2) RCW 71.36.030 (Children's mental health services delivery system--Local planning efforts) and 1991 c 326 s 14.

NEW SECTION. **Sec. 14.** Captions used in this act are not part of the law.

NEW SECTION. **Sec. 15.** If specific funding for the purposes of sections 4, 5, 7, 8, 10, and 11 of this act, referencing the section by section number and by bill or chapter number, is not provided by June 30, 2007, each section not referenced is null and void.

--- END ---

Attachment B

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of a mental illness.**	* **Must demonstrate moderate functional impairment in at least one life domain requiring assistance in order to meet the identified need AND-** * **Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least one life domain requiring assistance in order to meet the identified need AND-** * **Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One</u>, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

- High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
- At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
- Two or more hospital admissions due to a mental health diagnosis during the previous two years
- Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
- Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
- Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).