October 2, 1994 Introduced By: Jane Hague

94-420sm.doc/dgs Proposed No.: 94-420

MOTION NO. 9399

A MOTION adopting the prepaid health plan of the human services department/mental health division.

WHEREAS, the restructuring of the State Medicaid program for mental health services offers regional support networks the opportunity to manage all outpatient mental health services for Medicaid-eligible adults and children as a prepaid health plan, and

WHEREAS, the access and quality of service will be enhances by regional support network management of mental health services for the Medicaid population, and

WHEREAS, the King County council has directed the county executive, through Ordinance 11130, to submit a recommendation on whether the county should manage outpatient mental health services;

NOW, THEREFORE BE IT MOVED by the Council of King County:

The prepaid health plan dated June 30, 1994 (Attachment A) is hereby adopted with the following additional policy statements:

1. The regional support network/prepaid health plan will direct through its policy and contractual language that the mental health delivery system participate in a coordinated continuum of care for children and adults. That coordination includes all agencies funded by King County government and extends beyond to include schools, other community-based

health and human services providers, and any relevant state services.

2. King County is committed to providing ethnic and sexual minorities and the deaf and hearing impaired equal access to publicly funded mental health services and to appropriate levels of service, choice of providers and culturally relevant services. Existing specialized mental health services for ethnic and sexual minorities and the deaf and hearing impaired, therefore, shall be maintained and enhanced for the purposes of ensuring equivalency and meeting the new requirements to provide a complete range of community support services.

BE IT FURTHER MOVED, The mental health division is hereby directed to provide to the council by December 1, 1994 the design and work program for monitoring and evaluating the implementation of the prepaid health plan proposal. The design and work program shall include baseline data regarding current system performance, a progress report to the executive and council on implementation of the prepaid health plan after the first 6 months and an evaluation of the impact of the new system after its first year of operation. The evaluation shall measure changes in service use, expenditures and revenues and outcomes by client groupings -- by tier or need level and by target groups including children, adults, older adults, ethnic and sexual minorities, deaf and hearing impaired, and medically compromised homebound. The design

shall also provide for review and recommendation by consumers, advocates and independent treatment and evaluation professionals.

PASSED this 10th day of October, 1994.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Passed by a vote of 13-0.

Kent Pullen
Chair

ATTEST:

Gerald A. Peterson
Clerk of the Council

Attachment A: King County Regional Support Network Proposal to Become a Prepaid Health Plan for Outpatient Mental Health Services

9399

DRAFT

KING COUNTY REGIONAL SUPPORT NETWORK

PROPOSAL TO BECOME A PREPAID HEALTH PLAN

FOR OUTPATIENT MENTAL HEALTH SERVICES

CONTENTS

MENTAL HEALTH REFORM

Stage One: Regional Support Networks

Stage one of mental health reform took place in 1989 when the Washington State Legislature passed Second Substitute Bill (2SSB) 5400, the Mental Health Reform Act, which fundamentally changed public mental health service delivery. Along with the policy changes of 2SSB5400, the State significantly increased funding for community mental health services.

Key State mandated elements of the first stage were:

- Establishment of local mental health authorities called Regional Support Networks (RSNs), which were charged with the responsibility of managing State funded mental health care;
- Development of local resource management capability within RSNs to assure access and quality of care;
- Emphasis on case management, individualized service planning, housing, employment, and other community supports;
- Creation of comprehensive crisis response systems; and
- Local responsibility for 85% of short-term involuntary inpatient care.

Since 1990 King County RSN has made considerable progress in meeting the intent of 2SSB5400. It has increased housing available to persons with mental illness by 112%; controlled and managed use of the State hospital; enhanced its crisis response system; implemented case management services for adults, including 24 hour support when needed; significantly exceeded the goal of providing short-term involuntary care in the local community; expanded children's service capacity with emphasis on coordination with other child-serving systems; created a management information system which allows more accurate reporting of service delivery and established a baseline for quality and outcome management.

Stage Two: Medicaid Waiver and Mental Health Managed Care

Medicaid Waiver

The 1989 reform excluded management of the federal Medicaid resources from the RSN responsibility. Local providers are reimbursed directly by the state on a fee for service basis for Medicaid services. These providers use State funding received through their contracts with the RSN to supply required match (48%) for the Medicaid dollars.

The current system lacks incentives to manage growth of Medicaid expenditure; and ineffectively splits the management of Medicaid state matched dollars between the State and the RSNs. If it remains unmanaged, the state expenditure for community mental health, which is already in the top ten per capita investments in the nation, would be pushed higher. This is a very unlikely prospect in the 601 climate.

In response to these problems, the Department of Social and Health Services (DSHS) secured a Medicaid waiver from the federal government to consolidate State and Medicaid dollars under a single regional entity which will manage care as a Prepaid Health Plan (PHP). (See Appendix 1 for the consolidation of funding streams.)

The goals of the waiver are to control Medicaid expenditures, to improve service outcomes; and to consolidate state and Medicaid revenues under a single regional entity.

All Medicaid recipients are considered eligible, those seeking care will be authorized to receive services if they meet the definition of medical necessity. Services will be provided based on what an individual will accept and a tier 1, 2, or 3 level of service. Tier 1 individuals need brief or occasional service, including aftercare following a more intense illness. Tier 2 individuals have a persistent mental illness that requires a moderate level of care and occasionally intense services. Tier 3 addresses the needs of persons with severe and persistent mental illness who require intensive service over extended periods of time. (See Appendix 2 for adults and children's medical necessity criteria by tier.)

The current State Medicaid waiver has been authorized by the federal government's Health Care Financial Authority (HCFA) until July 1995. The State expects the waiver to be re-authorized by HCFA. For the remainder of this biennium, participation in the waiver is optional with RSNs determining whether to and when to shift Medicaid mental health services to the prepaid model. Once the RSN determines that the prepaid model should be implemented, the State must select the most qualified organization to become the PHP. The waiver establishes the criteria for PHPs, which were designed specifically for RSNs to implement. However, other organizations could theoretically meet the criteria. If there is competition from other organizations to become the PHP, the State must determine who is best qualified. To date, PHPs have been implemented in three RSNs and there has been no competition. However, with the interest shown in King County to date by both local and national organizations, there may be competition at the State level.

Stage Three: Health Care Reform

Health Care Reform

Managed care is basic to the health care reform models being developed in Washington State, and under consideration at the federal level. When the Washington State Health Services Commission reaches its recommendation on the uniform benefit package, mental health services will be part of it. In Washington State, public clients will be folded into health care reform beginning in 1997. By 1999 the uniform benefit package for long term care will be available.

PHP RECOMMENDED SCENARIO

This plan proposes that King County, through its Regional Support Network, managed by the Department of Human Services, contract with the state to become the PHP for outpatient Medicaid services.

As a PHP, the RSN will manage Medicaid funding and be responsible for all medically necessary outpatient mental health services for the Medicaid population. This new responsibility offers the opportunity to improve the management of care and resources for all populations served by the RSN. The PHP management structure and services will be used for both Medicaid and non-Medicaid recipients. The new plan will:

- Establish a risk based contract with the State to manage outpatient services to the Medicaid population;
- Increase access and capacity for children's services significantly;
- Increase access and capacity for adult services;
- Incorporate management of access to Medicaid voluntary inpatient care and link Medicaid outpatient and inpatient care management under a single structure;
- Determine access based on medical necessity criteria and authorize care through a tier structure;
- Manage client care through outcomes and quality indicators rather than service units or programs;
- Set direction for quality improvement policies and procedures and establishment of system standards;
- Change provider contracts within the current network and create the potential for adding or eliminating providers in the network based on performance and consumer demand;
- Change the reimbursement mechanism from fee-for-service to a case rate model, with case rates established by tier; and
- Change the structure and function of the Mental Health Division of the Department of Human Services, including the creation of a public/private partnership for management of care.

Impact on Clients and their Families

- It will be easier to get services in the public system. Eligibility will be broadened beyond current enrollment criteria and more people will be served. Clients will continue to be able to access care directly through the PHP's network of providers, but entry will be enhanced by creation of centralized phone lines which will link people to network providers. Access will also be enhanced by adding providers to the existing children's network.

- All persons currently in service will be assessed based on the new medical necessity criteria. If they meet the criteria, they will be authorized to a tier level. If they do not meet the criteria, there will be a transition period for them to move out of the system. Very few of these persons are not expected to meet the medical necessity criteria.

- It will not be necessary for current consumers who become authorized by the RSN/PHP to change providers when the RSN/PHP is implemented.

- The current array of services will be continued and an additional service, brief focused intervention, will be added. The RSN/PHP will not stipulate what services must be provided for each consumer, but will assure by contract, that providers have the necessary array of services to meet individual client needs. Consumer clubhouses will also be included in the array of available services.

- The RSN/PHP will maintain its commitment to case management models, and out-of-facility care for persons authorized at the higher tier levels (tiers 2 and 3). Availability of 24 hour case management will be required at these tiers for all persons.

- The duration and intensity of services will be more closely managed. Depending on the tier, people will be authorized for services for no less than three months, and no more than one year. The intensity of services will depend on individual client need and willingness to receive care. Each authorized course of service will have specific outcomes identified by the client, the RSN/PHP, and the provider. At the end of the authorized period of service, a client who continues to meet the medical necessity criteria may be authorized for additional care at the same or a different level of intensity and duration. However, continuation of care will not be automatic. The goal of all treatment will be to stabilize, rehabilitate where possible, and discharge or maintain at the least restrictive tier level. Some persons currently served in the RSN system will receive less care under this model.

- The number of adults and older adults will increase slightly. The number of children will increase markedly. The tier structure should ensure that persons with complex medical and psychiatric problems receive appropriate levels of care. Outside of the tier structure the PHP will continue with the current crisis response system including specialized crisis services and hospital diversion beds.

- Persons who have a severe mental illness, who are poor, and who do not have Medicaid funding available will still be eligible to receive care through the RSN/PHP. Access to care will be based on the same medical necessity criteria, and the service array will be the same. However, if demand exceeds projections, persons without Medicaid coverage may be placed on wait lists for care. The wait time policy for non-Medicaid persons may be longer.

- Populations of ethnic minorities and sexual minorities are expected to increase slightly.

- To advocate for client and family needs, the RSN/PHP will establish an ombuds service. The goal of this service is to ensure that consumers and their families and/or guardians have access to advocacy, recourse, and information which will enable them to receive quality, medically necessary mental health services.

- Clients and family members will also have the opportunity to influence the overall design and on-going improvement of the RSN/PHP. They will make up 51% of the King County Mental Health Board's Quality Council, and will continue to be represented on agency boards and the King County Mental Health Board.

Appendix 3 diagrams consumers access to services.

Impact on the Provider Network

- The following services/contracts will not change significantly as a result of PHP decisions:
  - Evaluation and treatment facilities
  - 24-hour coverage for initial outreach, and investigation and detention under the Involuntary Treatment Act
  - 24-hour telephone line for crisis counseling and referral provided by the Crisis Clinic
  - Geriatric crisis assessment and stabilization
  - Hospital diversion beds for adults and children
  - Respite services for adults and children
  - Coordinating agencies/IST/Flex Funds
  - Consumer projects
  - Parent advocacy project
  - Access to Community Care and Effective Services and Supports (ACCESS)
  - Projects in Assistance for Transition from Homelessness (PATH)
  - Community Diversion Project
  - Long-term Rehabilitation Residential Beds

- The following new services will be contracted outside the PHP tier structure:

  - Region wide mobile children's crisis response and stabilization team.
  - Language interpretation bank to support crisis services.

- The following services will change as a result of the PHP decision:

  - Lead agency role will be amended to include only:
    Residential placement and subcontracting of residential congregate care providers.
    Western State Hospital discharge coordination as in current contracts.

  - Supervised living contracts will continue to be managed through lead agencies. Each agency will be paid a single rate for board and domiciliary care. In addition, each residential provider may provide treatment services to residents, and be paid by community mental health centers from their tier rate authorized for the individual.

  - All services will be authorized by the PHP. At least tiers 2 and tier 3 will be pre authorized. Tier recommendations will be made by contracted providers based on PHP medical necessity criteria. These criteria will replace current eligibility requirements.

- All providers in the network will need to be certified by the PHP.

- There will be an add-on to the tier rates for all persons who are ethnic minorities, sexual minorities, or deaf and hearing impaired. This is because achievement of treatment outcomes will require specialized consideration of the impact of culture on communication, diagnosis, assessment, and treatment planning. The add-on is based on the standardized hour of additional consultation every 90 days of authorized treatment.

- Licensed community mental health centers in King County which meet the PHP's certification standards will have the opportunity to bid for contracts through a Request for Proposal (RFP) process. This process will determine the distribution of projected users by tiers over the provider network. Contracts will be written for a guaranteed minimum and additional availability and capacity by tier.

- During 1995, additional providers who are not currently part of the RSN may be certified by the RSN/PHP. A vendor agreement will be signed with all certified providers. These additional certified providers will be used to provide services when the existing network cannot meet demand within wait time standards.

- Reimbursement for tier services will be based on the case rate methodology. Rates are based on 1993 actual service experience aggregated by the tiers established by the Medical Necessity Work Group. Tier payments will differ slightly for adults and children, with the median number of service hours for children being slightly higher at some tiers.

- Providers will assume a portion of the financial and utilization risk as a consequence of the case rate reimbursement methodology. They will be at risk if actual average service level delivered within each tier exceeds the projected median use.

- For Harborview Medical Center (HMC), the RSN/PHP may purchase directly several unique region wide services. Possible areas include training, specialized assessment consultation for adults with complex medical and psychiatric problems, and specialized crisis stabilization services. For the majority of services HMC will operate like other providers within the RSN/PHP network.

Impact on Existing RSN Adopted Plans

Under the proposed plan, the RSN/PHP will manage the majority of its services for both Medicaid and non Medicaid clients through the PHP structure. The values that drove the publications written for the first stage of reform, *A New Direction* and *Foundations for the Future*, will not change. They include: diversity, equitable access, partnerships in development of services, building services around individual strengths, service delivery in the least restrictive appropriate setting, coordination and collaboration with other health and social service systems, evaluation of services, quality, and advocacy.

The PHP proposal continues the policy direction established in 1989 for adults and in 1990 for children. It maintains a priority on serving the most acutely and chronically mentally ill adults, and seriously emotionally disturbed children. This is accomplished through the PHP tier structure and medical necessity definitions. The PHP will continue to require the 24-hour case management function for all tier 2 and 3 adults and children. The plan continues a focus on children within the context of their families and protects the current gains in system coordination. For children, both the Interagency Staffing Teams (ISTs) and the Regional Policy Team will be continued. The PHP maintains and enhances the priority for underserved populations, children, elderly, ethnic minorities, sexual minorities, and deaf and hearing impaired. Through a centralized authorization process it encourages individualized treatment more aggressively than the current plan. It maintains the gains achieved in the crisis response system while adding new crisis response capacity for children. It maintains current structures which have successfully managed the ISTs and flex funds in the children's system, and the residential placement and Western State Hospital discharge functions in the adult system. It continues and strengthens considerably the RSN emphasis on management of care and resources. It enhances the client and family role in the design and monitoring of the system as a whole and expands the avenues available to individual clients and families for problem resolution and advocacy. It enhances client choice of service provider and offers more information to families and individuals to guide that choice.

The PHP calls for an increase in adult services, primarily related to expanding eligibility for care to those persons whose illnesses may be managed with brief intervention. For children, the PHP calls for significant increases in care at all levels of intensity from early and brief intervention to intensive long-term support. System capacity will match projected demand in *Foundations for the Future* by the end of 1996. At that time, the RSN/PHP expects to serve approximately 15,000 adults and 10,000 children.

The RSN values, which have not changed, and changes in *A New Direction* and *Foundations for the Future* are summarized in Appendix 4.

Impact on King County Mental Health Services

PHP

Moving to the PHP structure will require substantial changes in the management of the existing King County RSN. PHP management includes the following critical functions:

- Financial planning and management
- Authorization of care
- Billing and reimbursement
- Provider certification, contract management, audit, and technical support
- Utilization management
- Quality management, including outcome management

The RSN does not currently certify providers. RSN operations include the functions of: financial planning, authorization of care for children through the EPSDT program, contracting, billing and reimbursement, and utilization review/quality assurance. However, each of these functions is designed for a grant managed and/or fee-for-service system. They must all be expanded, restructured or replaced to support a managed care system.

Hospitalization

Appropriations Bill SSB5968 transferred funding for Medicaid voluntary mental health hospitalizations, in the 1993-95 biennium, from Medical Assistance to the State Division of Mental Health (DMH). DMH is required to work with the RSNs to design and implement ways to reduce avoidable hospitalizations. RSNs which are able to reduce voluntary and involuntary hospitalizations below baseline level forecasts will receive bonus payments for their performance. The system must be operational by January 1995 and coincides well with the implementation of the PHP for outpatient care.

The hospitalization management responsibility is not contingent upon the PHP decision, nor does it carry financial risk in the 1993-95 biennium. It is, however, an essential component of managed care and gives the RSN/PHP an important tool to manage the overall system.

Other RSN Responsibilities

The RSN will also retain its overall responsibility, as defined in RCW 71.24 and 71.05, to serve the acutely and chronically mentally ill adult and the seriously emotionally disturbed child. The RSN contract will also maintain requirements to serve children, elderly, and ethnic minorities at least at their relative proportions in the community-at-large (parity). The Western State Hospital risk pool agreement will continue as will requirements for cross-system collaboration with Aging, Developmental Disabilities, Division of Alcohol and Substance Abuse, AIDS network, the Division of Children and Family Services and other child-serving agencies.

The RSN will also require management systems for crisis response services, for federally funded projects like the ACCESS grant for homeless mentally ill persons, for Interagency Staffing Teams which coordinate treatment planning for multi-system children, and for parent advocacy and consumer run projects.

The new RSN/PHP management structure must manage the PHP functions and the new hospitalization management functions as well as the remaining RSN functions, in an integrated and cost effective manner. It must also be capable of implementing the new PHP by January 1995.

Role of King County Mental Health Board

The RSN has a citizen advisory Board which guides policy and resource decisions for the RSN. The Board is required by RCW, and defined by the WAC. It operates under County Ordinance No. 10560. Under the RSN/PHP structure the emphasis of the Board will be to:

1. Advise the King County Executive, King County Council, on mental health policies.
   a. Review and evaluates mental health needs and services on King County.
   b. Recommend methods of distribution of available non-PHP resources to the community.
   c. Monitor and ensure access to quality, comprehensive, and culturally sensitive mental health services for adults and children.

2. Review reports from the mental health division regarding the system's trends, outcomes, quality indicators, and consumer satisfaction, and based on results, recommend further study or changes as necessary.
   a. Review and forward Qaulity Council recommendations to the RSN/PHP Administrator.
   b. Review and report on Ombuds activities.

3. Monitor the mental health system's financial viability through review of annual budgets.

4. Provide education/information to the residents of King County regarding mental illness and public mental health services. Periodically gather information from the community, mental health service providers and consumers of service.

Role of the Ombudsperson

To advocate for client needs, the RSN/PHP will establish an ombuds service. The ombuds person/s will report directly to the RSN/PHP manager. The goal of this service is to ensure that consumers and their families and/or guardians have access to advocacy, recourse, and information that will enable them to receive quality, medically necessary mental health services.

ALTERNATIVE SCENARIOS

These scenarios have been analyzed by the RSN but are not recommended.

Alternative 1:
The County does not approve this plan for the RSN to manage the PHP. The State must either select another organization to manage the PHP or employ other cost containment measures through the RSN to control Medicaid expenditures.

Consequences:
If the State selects another organization to manage the PHP, the consequences are the same as those listed above.

If the State chooses to control growth of Medicaid expenditures through the current fee-for-service structure, it will use one or more of the following approaches: reduce Medicaid rates for some or all Medicaid services; reduce the range of services which are reimbursed by Medicaid (all adult outpatient mental health services and some children's outpatient mental health services are considered optional by the federal government); pull dollars from the RSN contract to provide match of Medicaid services at the State level. These steps must be taken Statewide for all RSNs which are not PHPs.

This alternative has the additional disadvantage of not preparing the RSN provider network to operate in a managed care environment. With the passage of health care reform in this State (full implementation is to begin in 1995 and be completed in 1999), those organizations who expect to play a role must now be moving toward managed care. Historically, the County has invested heavily in its provider network and, in turn, those agencies have made a commitment to serving the public client.

Alternative 2:
The Metropolitan King County Council defers its decision on the PHP until July 1995 when more is known about health care reform.

Consequences:
Medicaid expenditures will continue to rise in an unmanaged fashion. The State will be forced to require the RSN to redistribute its existing resources; identify new resources to cover Medicaid match; or implement the Statewide strategies described above.

The provider network will lose an additional year in preparation for managed care. In the volatile and highly-competitive marketplace for health care, this year is crucial. King County RSN will also lose a strategic position in shaping mental health care reform.

The improvements in access and quality possible under the waiver will not be available to King County residents.

Any of these approaches where the RSN is not the PHP will have a detrimental effect on service access and quality. They will further the perverse incentives of the fee-for-service structure, and will undermine the ability of the RSN to manage the public mental health system.

Alternative 3:
The County approves this plan for the RSN to manage the PHP beginning in January 1995. The State, through its own selection process, selects a private entity rather than the RSN to manage the PHP.

Consequences:
The major portion of RSN dollars will be shifted to the PHP to match Medicaid dollars. The remaining dollars will be insufficient to support current RSN contract requirements.

State law requires RSNs to manage public outpatient and, established in this biennium, community inpatient mental health services. A separate PHP contract would not allow the RSN to fulfill its responsibilities and would create confusion. If this scenario were to take place, RSN staff would recommend that the County sever its RSN contract with the State. This would completely reverse the direction established in 1989 with the passage of 2SSB5400.

For consumers, local public accountability and all advantages of a single resource manager would be lost. The achievements in access and quality achieved in the first four years of mental health reform would be jeopardized. Interruptions in continuity of care for chronically ill persons who needed both PHP and RSN services would be more likely.

OUTCOMES, QUALITY INDICATORS, AND INCENTIVES

A key element of the PHP is shifting management focus from service units and programs to service outcomes. Adequacy of care for clients will be measured by achievement of outcomes. The performance of individual providers and the overall system will be measured by key quality indicators. There will be financial incentives for providers to achieve outcomes.

Outcomes

Outcome expectations are broadly defined for each tier level and individually established at the beginning of an authorized course of treatment. The care planning at all tiers will be more outcome focused than the current system.

The outcomes will include:

- Specific symptom resolution, reduction, and/or stabilization;
- Stable housing;
- Successful participation in community, school, day events, employment, and development of friendships and support networks;
- Prevention of hospitalization, incarceration, and out of home placement; and
- Prevention of violence related to mental illness/emotional disturbance.

Quality Indicators

The quality indicators will be collected and analyzed by provider agency, by service population, and for the PHP network as a whole. Indicators will include at least the following:

- Access: Ensure comparable utilization for individuals within the same tier; establish standards for wait times for non-emergent, and crisis care, and discharge from hospital and jail; language interpretation and cultural assessment for special populations

- Parity for underserved groups: Ensure state and locally defined underserved groups: children, elderly, ethnic minorities, sexual minorities, deaf and hearing impaired, are served at least in proportion to the general population.

- Restrictive Settings: Decrease admissions and length of stay for both voluntary and involuntary consumers; reduce rates of jail/juvenile detention days and recidivism

- Critical Incidents: Reduce intensity and frequency

- Client Satisfaction: Regular surveys and follow-up quality improvement activities

- Medicaid Enrollment: Increase the availability of funding for care

- Management of Highest Utilizers: Control cost and improve outcome focus

Incentives

The success of the PHP in service delivery can be measured by the achievement of both individual and system outcomes by providers. The over-riding incentive for providers to achieve the PHP outcomes is that good performance should ensure continuing business with the PHP, and may result in increased market share in the following year.

The following incentives are based on the premise that the PHP will not retain a separate pot of money to pay incentives, but that financial incentives for achieving outcomes must be directly related to areas where cost savings occur. This means that in the aggregate, if there are savings at the end of a contract year, they will be shared with providers.

Outpatient Incentives

- Goal: To control cost and improve outcome focus for the high utilizers

The providers who have success in moving 25% of their consumers receiving tier 3a and 3b services to lower tiers at the time of re authorization by achieving individual outcomes will receive a prorated portion of the system wide savings.

- Goal: To increase availability of care by increasing the ability to draw on federal funding for consumers.

To maximize funding available to the PHP, and to support funding assumptions, providers must assist their consumers to become Medicaid eligible. Providers who can assist 20% or more of their authorized non-Medicaid population who may be eligible to complete the paperwork to become Medicaid eligible, will receive additional authorizations to their quarterly minimum allocations.

Involuntary and Voluntary Inpatient Incentives

- Goal: To manage the State hospital risk pool agreement.

Currently the RSN has a target level which is a portion of the overall Western Washington census cap on use of Western State Hospital. The Western Washington RSNs are jointly at risk for not exceeding the negotiated cap. Bonus and penalty payments are prorated among participating RSNs.

The RSN/PHP network will use a similar approach for incentive payments. All providers who meet PHP contract outcome requirements will be eligible to share in incentive payments if hospital use is below the RSN/PHP target. The incentives will be prorated to their proportion of tier 2 and tier 3 clients served in the system.

- Goal: To manage and decrease use of local voluntary hospital admissions.

The RSN has the possibility of receiving bonus payments if voluntary hospital use is less than State projections. This bonus will be passed down to agencies.

The RSN/PHP network will use an approach similar to involuntary management as described above. All agencies who meet contract outcome requirements will be eligible to share in incentive payments prorated to their proportion of tier 2 and tier 3 clients served in the system.

FINANCIAL PLAN

The PHP/RSN system will be funded primarily by a combination of State and federal dollars. There are no expectations for local funding beyond legally mandated maintenance of effort funds. That requirement is handled through dedicated mental health millage and a very small allocation of current expense funds targeted to jail diversion purposes.

The RSN/PHP financial assumptions call for a 23% increase in Medicaid adult users and a 69% increase in Medicaid children's users between 1993 and 1995. (See Appendix 5 for growth trends). Children's services will continue to grow until 1996 and stabilize thereafter. This increase is possible without a significant increase in the allocation of State dollars to the RSN because the RSN/PHP model incorporates:

- More flexible use of Medicaid dollars under the waiver
- Improved collection and accounting for other third party resources - particularly Medicare
- Management of intensity and duration of services with emphasis on reduced utilization of high end users
- Change in the provider reimbursement structure which shares utilization risk with providers under a case rate system, and eliminates the incentive to over-serve which is inherent in a fee-for-service structure
- Central authorization of care based on a tier structure which is defined by medical necessity and establishes standards for intensity and duration of care. Ongoing services must be re-authorized on a regular basis
- Aggressive efforts to get eligible persons on Medicaid rolls

The assumptions which underpin the service/financial model are listed below. The model is interactive and flexible. (Appendix 6 details financial model and service projections by tier.)

1. **Annual Medicaid eligibles: 91,971 adults; 115,249 children**
   An estimated 25,000 additional children will become eligible in July 1994 when the Medicaid eligibility rises to 200% of poverty for children. Our model is anticipating that 15,000 of those children will sign up in 1994-1995 and that the remaining 10,000 will sign up in 1996.

2. **Penetration rate (proportion of eligibles who are users):**
   1st Half 1995: Adult 10.5%, Child 5.0%
   2nd Half 1995: Adult 12.0%; Child 7.5%

   1993 penetration rates are 10% for adults and 2.5% for children. Our actuaries, Coopers and Lybrand, agree with our assessment that penetration will take a while to build up to the levels expected based on the mathematical calculations, particularly those proposed for children. Due to these issues of system start-up and capacity building, we are proposing little change for adults and children for the first half of 1995. In the second half of 1995, we anticipate that adults will build up to the overall expected penetration rate and that children will increase significantly, but will still be less than the expected penetration rate of 8.7%. The penetration rate should be achieved by 1996, and the financial plan incorporates that growth.

3. **Case mix by tier**
   For adults, it assumes that we begin with a base of Medicaid consumers who are similar to those who were served in calendar year 1993 (the latest period when data is available).

It is assumed that for new consumers entering service in 1995 there will be a higher proportion of Tier 1 users. The model also projects a decrease in the number of users at the highest tier (3b) due to closer management of care.

All children in 1995 are assumed to have the same distribution as those served in calendar year 1993. A similar strategy is used to project a reduction in the number of cases at the higher tier to a lower tier due to closer management of care.

4. **Medicare crossover payments: 20% Medicaid/80% Medicare**
The PHP will pay 20% of the case rate for all adult Medicare crossovers and have agencies bill Medicare for maximum allowable costs. 29.12% of the Medicaid adult population are projected to have Medicare coverage too. This is based on the fact that in 1993, 34.6% of all adults served in the system had both Medicare and Medicaid coverage. For 1995 we have assumed that new Medicare crossovers will occur in Tiers 2 and 3 only, but at the 1993 historical rate of 34.6%. This gives us a total projected crossover level in 1995 of 30.6% of the adult caseload. No children are assumed to have Medicare coverage.

5. **Children's "risk status": no risk option**
The PHP can choose a "no risk" option for children. In this scenario the upper payment limit (UPL) for Medicaid funding is waived. The PHP access to federal Medicaid dollars is limited only by the availability of match. If this option is selected, the total amount of revenue possible for the system grows considerably, but a greater proportion of the match must be targeted to children's Medicaid services, and thus reducing the funding for adult services. The "risk" alternative lids the UPL on historical utilization adjusted for Medicaid case load growth. A risk contract does not limit our liability to serve children.

6. **% Non-Medicaid: approximately 30% for adults, 25% for children**
The proportion of Medicaid and Non-Medicaid services will be set by tier, with a higher non-Medicaid proportion in the lower tiers. This percentage would increase the proportion of Medicaid in all tiers as compared to 1993. It requires more aggressive efforts by providers to get eligible individuals on the Medicaid rolls. Our current picture is approximately 50% non-Medicaid. Although 1993 service hours are split approximately 75% for Medicaid recipients and 25% in 1995 we expect service hours to be the same for Medicaid and non Medicaid.

7. **Administration: 5%**
The PHP waiver allows for a 5% administrative match (a separate administrative fund) on all Medicaid dollars. The current RSN administrative percentage is 6.5%. Coopers and Lybrand reports that industry standards for administrative costs for monitoring managed mental health programs are in the range of 6% to 8% of total funds. The current model at 5% is now being reviewed for feasibility.

8. **Risk reserves:**

Excess Utilization Risk Pool	$2,700,000
Risk Reserve:	$2,300,000

The excess utilization risk pool is 5% of the expected expenditure in the areas the PHP bears risk: case managed outpatient services, and cultural interpretation add-on. In addition $300,000 is included for Western State Hospital risk pool agreement, and $128,000 for Native American freedom of choice exemptions. The fund is to support excess utilization, case mix adjustments, and authorized exceptions to policy. Any recoupments from the case rate model will be added to the fund. The fund will be spent down over the course of a year and any savings will be shared with providers in incentive payments.

The risk reserve fund is 5% of the expected expenditure in the areas the PHP bears risk. It comes from fund balance and also satisfies the County requirement to retain a 1% target fund balance.

Our actuaries support a risk reserve of 10% of expected expenditures where the PHP bears risk.

9. **RSN Services**

Existing contract services are budgeted with a 2.6% COLA for 1995.

10. **Benefit package**

The benefit package is structured into seven tiers (1a, b; 2a, b, c; 3a, b). Maximum hours, intensity of service, and duration of service all vary between tiers. The basic array of services will include all current Medicaid service modalities. Children will have a higher number of median service hours at some tiers.

See Appendix 7 for the case rate model.

11. **Standard hourly rate**

The standardized hourly rate multiplied by the relative value unit for service is the basis for determining the rate. The same standardized hourly rate ($63.00) has been used for both children and adults. The standardized hourly rate was derived from the provider agency self-reported survey conducted in the summer of 1993. $63.00 is the median reported cost for individual face-to-face services provided in-facility for adults. This figure has been supported by our actuaries and a national managed care consultant.

1995 shows an increase in total revenue from $44,271,529 in 1994 to $79,320,488 in 1995: a 79.2% increase.

The majority of the change is due to increased outpatient Medicaid dollars. Although not part of the projected revenues, the RSN/PHP includes expected bonus payments (Medicaid and State dollars) for decreased hospital use. Appendix 8 contains the financial plan for the period of 1995-1997. The detailed 1995 budget which supports the RSN/PHP plan will be submitted to the King County Executive with the Department of Human Services budget submittal.

RISK MANAGEMENT

Currently, the RSN holds a limited risk based contract with the State for community mental health services. The two areas where risk exists in the current contract are:

1. A risk pool agreement in relation to use of Western State Hospital.

2. Assurance that King County will make available State match to support Medicaid fee-for-service billings.

The PHP contract will replace the second risk with a more explicit requirement to assure provision of medically necessary outpatient mental health services for the Medicaid population. Because Medicaid is a federal entitlement program, the RSN/PHP must serve any Medicaid recipient who meets medical necessity criteria. This PHP plan has carefully identified potential legal and financial risks and has developed management strategies for each.

PHP/RSN legal risks relate primarily to assuring that authorization for care is applied fairly and consistently across the entire population seeking services. The primary tools proposed to address legal risks are:

1. Clear written notification of mental health benefit to entire Medicaid population, 1-800 phone line to provide information on eligibility and benefits;

2. Clearly defined and published medical necessity criteria that are approved and administered by the PHP medical director;

3. Adequate protocols and staff training under the guidance of the medical director to assure consistent application of medical necessity criteria in the authorization process;

4. Audit and quality improvement intervention; independent client satisfaction survey, an ombuds service to advocate for client needs, and a formal grievance procedure.

PHP/RSN financial risk is addressed by the following four strategies:

1. Control who, and how much services are provided to individuals. Ensure individuals receive appropriate and sufficient, but not excessive care. Manage these risks through a centralized PHP authorization process which sets clear limitations on intensity and duration of care.

2. Assure flexibility in both the service model and provider contracts to meet changes in service demand promptly.

3. Identify sufficient reserves to cushion against unforeseen changes. To cushion the RSN/PHP against unexpected changes in penetration or case mix, the financial plan includes two types of risk reserves. The first, an excess utilization risk pool, is built at 5% of the PHP service budget plus an additional $300,000 to cover the Western State Hospital risk pool exposure. This fund is replenished annually and if not fully expended, the savings are shared with providers through incentive payments. The second risk reserve contains fund balance equal to 5% of the PHP budget. This fund is available if projections are significantly different than actual experience. If depleted, it must be replenished through reductions in services and/or administration.

4. Limit accessibility of service to non Medicaid persons through wait lists and referrals to other service agencies if resources do not meet demand.

Appendix 9 contains a detailed description of risks and risk management strategies.

Consultant actuaries, Coopers and Lybrand, and a national managed care expert, Robert Dyer, have reviewed the proposed PHP plan. Their reviews are in Appendix 10. Both sources confirmed the financial assumptions and the risk management strategies to be appropriate and sufficient.

PROPOSED MANAGEMENT STRUCTURE

There are few models of managed care in the public mental health system. The majority of experience comes from managed behavioral health benefits provided to insured populations rather than those who receive public entitlement programs. Because of the complexity of managed care, the risk element of the PHP contract, and the pressure to implement quickly, the RSN is considering a private sector management partner.

There are advantages and disadvantages that private partnership would bring to PHP management in King County.

Potential Advantages to Contracting with a Private Firm

- The flexibility and perceived efficiency of a private firm which is not encumbered by the regulations and costs currently imbedded within our government systems.

- Expertise in care management and training/technical support that an experienced firm would bring to the provider network.

- Uncertainty regarding the RSN role in management of mental health services under Health Care Reform and the potential advantage of purchasing management services rather than developing an in-house infrastructure.

Potential Problems in Contracting with a Private Firm

- Lack of knowledge or experience with the public entitlement population in general and King County's population in particular.

- Potential for inefficiency, with an approach where two entities (RSN and PHP contractor) must coordinate functions and systems.

- Poor fit of management systems designed for an insured population with a provider network designed to support a public population.

- Assuring accountability for public funds through an arms-length relationship with a private firm.

A formal bid process identified US Behavioral Health (USBH) as the most qualified to be considered for a public/private partnership with King County. Discussions with USBH are focused on two possible options for a public/private partnership.

Option 1

The RSN negotiates a full-risk contract with US Behavioral Health to manage the PHP. This option offers the most initial protection from liability; allows use of USBH existing systems and procedures adapted to King County; may be the least costly for PHP management (but not necessarily overall for RSN/PHP management); allows for more management flexibility and speed with regard to staffing, contracting, financial controls; and may be relatively more feasible to implement within the timeline.

Key Issues:

1. Can a private firm with little experience in the public sector adjust its protocols and systems to appropriately manage the King County RSN provider network, and meet the needs of the King County population regarding publicly funded mental health services?

2. Does the County have the legal ability to contract out this work to a private firm which may be similar to work currently done by County employees?

Option 2

The RSN negotiates a non-risk contract with USBH to purchase their systems and technology. The RSN holds the risk. This option allows the RSN to use the expertise and systems of USBH. It makes the integration of RSN/PHP functions more feasible and potentially more cost effective.

Key Issues:

1. Can current County policies and procedures be streamlined quickly and efficiently in order to meet the needs of the PHP? Policies include:
   - Personnel Management e.g. ability to recruit and lay off staff rapidly
   - Contract Management e.g. ability to recruit and engage service providers rapidly, and to amend contracts in a timely manner
   - Financial Management e.g. ready access to reserve and supplemental funds, and more aggressive investment policies

2. Can King County staff with technical systems support, bring up the new system by January 1, 1995?

Specifics of the public/private partnership and the implementation plan will be proposed in the 1995 budget submittal and the 1994 supplemental appropriation.

APPENDICES

1. Consolidation of Funding Streams

2. Medical Necessity Criteria and Outcomes

3. Consumer Access to Services

4. RSN Values and Changes to Existing Plans

5. King County and State Medicaid Growth Trends

6. King County Prepaid Health Plan Financial Report
   - Table 1 KCPHP Summary Report
   - Table 2 KCPHP Statement of Revenue & Expense
   - Table 3 Medicaid Summary Data Estimates
   - Table 4 Medicaid Statistics
   - Table 5a Medicaid Adult Service Volumes
   - Table 5b Non Medicaid Adult Service Volumes
   - Table 5c Medicaid Children Service Volumes
   - Table 5d Non-Medicaid Children Service Volumes
   - Table 6 Estimated Medicaid Annual Revenue
   - Table 7 Cultural Interpretation Add-On for Adults and Children

7. Case Rate Methodology

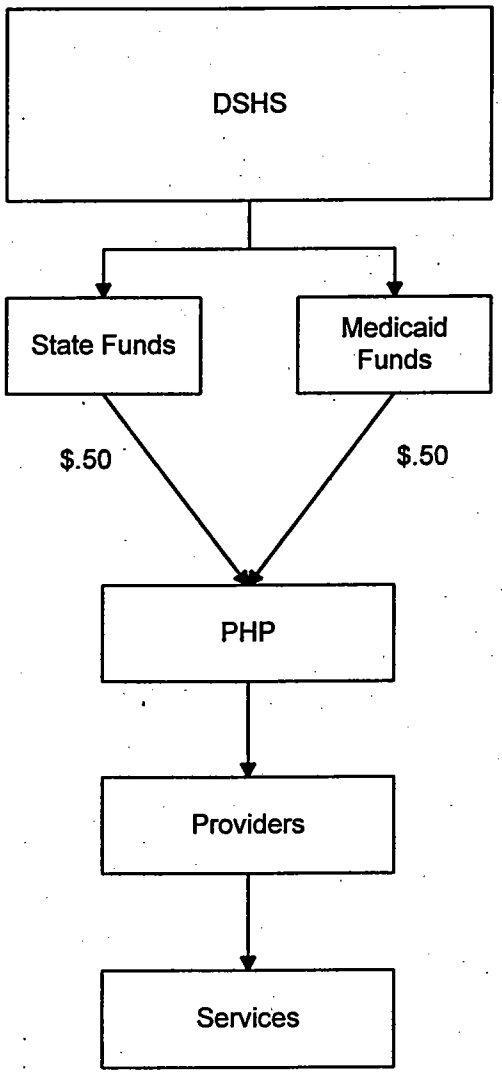
8. 1995-1997 Financial Plan

9. Strategies for Managing Legal/Financial Risk

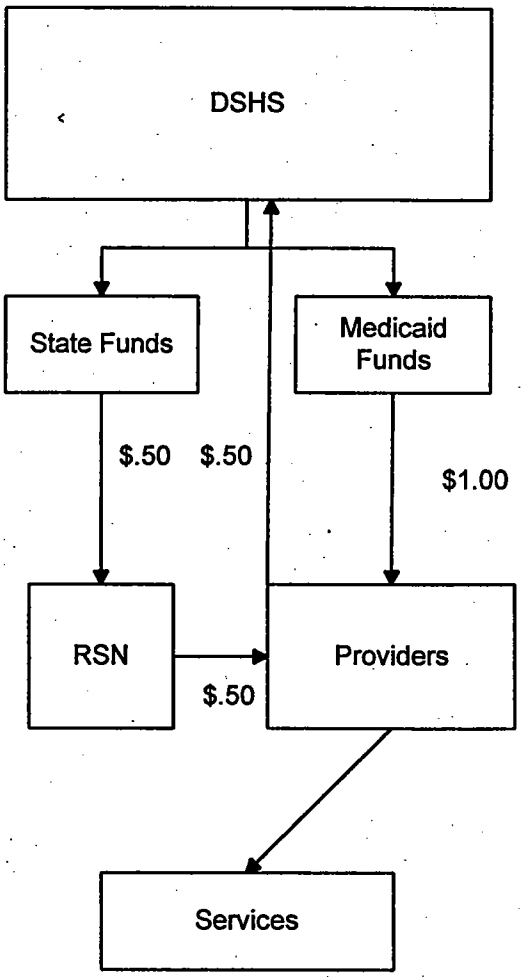
10. PHP Plan Review
    - A Coopers and Lybrand
    - B Robert Dyer

MENTAL HEALTH MEDICAID REFORM

PROPOSED OUTPATIENT MEDICAID FLOW
UNDER PHP MODEL



CURRENT OUTPATIENT
MEDICAID FUND FLOW



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PART III

CRITERIA

Ia). ACUTE CARE: ADULTS

A. ACUTE VOLUNTARY PSYCHIATRIC INPATIENT CARE

1. Admission Criteria
   a. A psychiatric condition which requires 24-hour medical/psychiatric and nursing services and is of an intensity such that care can be appropriately provided only at an acute level of hospital care; and
   b. Services in an acute care facility can reasonably be expected to significantly improve the patient's psychiatric condition so that 24-hour inpatient medical/psychiatric and nursing services will no longer be needed; and
   c. There is a plan of treatment, discharge and follow-up care which is specific to the psychiatric symptoms which precipitated acute inpatient psychiatric treatment.

2. Continued Stay Criteria
   All of the above criteria continue to be met.

B. ACUTE INVOLUNTARY PSYCHIATRIC INPATIENT CARE

1. Admission Criteria
   a. Face to face evaluation by a CDMHP, and
   b. Criteria for involuntary detention/commitment under RCW 71.05 have been met; and
   c. All appropriate and available less-restrictive treatment options, including voluntary hospitalization, have been ruled, or
   d. A commitment decision has been made by the Superior Court.

2. Continued Stay Criteria
   a. The patient's psychiatric condition continues to require 24-hour medical/psychiatric and nursing services and is of an intensity such that care can be appropriately provided only at an acute level of hospital care; and
   b. The patient is unable or unwilling, in good faith, to abide by the admission conditions of a voluntary hospitalization; or
   c. The length of stay has been extended due to court processes.

C. CRISIS ALTERNATIVE SERVICES

1. Population eligible for services: All individuals for whom a mental disorder cannot be ruled out and who are in need of crisis/emergency services to prevent imminent hospitalization or incarceration, harm to self or others or serious decrement in functioning.

2. Admission Criteria
   a. Initial crisis outreach:
      1) All population-eligibles, and
      2) Determined according to the standardized Initial Telephone Screening and Referral Acceptance protocol developed by the KC RSN Crisis Response Task Force, effective April 1, 1994.

b. Geriatric assessment services:
   1) 60 years of age or older, and
   2) not enrolled in the mental health long term care system, and
   3) physically and/or medically compromised, or
   4) physically disabled, or
   5) lacking in family/friends able and willing to provide the support necessary to ensure health and safety, or
   6) detention is imminent, or
   7) the person is refusing services, or
   8) an assessment for differential diagnosis is needed.

c. In-Home Crisis Stabilization:
   1) person or family is assessed to need in-home services in order to resolve/ameliorate the crisis; and
   2) services needed are short-term; and
   3) services will ensure that the safety of the person and/or others is protected.

d. Respite services:
   1) the person lives in a community-based situation in which supervision and care is provided by a family member/caregiver, and
   2) the family member/caregiver requires temporary relief from the immediate care responsibilities, or
   3) the person, for safety reasons (from self, from others, or for others), requires temporary alternative housing.

e. Hospital diversion beds, adults:
   1) assessed by the CDMHP to be at immediate risk for voluntary or involuntary hospitalization, and
   2) based on the assessment of the CDMHP, the person exhibits behavioral control such that (s)he can be safely managed in a less restrictive setting.

f. Homebound in-residence services:
   1) assessed by the CDMHP to be at immediate risk for voluntary or involuntary psychiatric hospitalization, and
   2) homebound because of medical, physical, cognitive and/or psychiatric disabilities, and
   3) requires temporary supervision to ensure that personal safety, or the safety of others, is protected.

3. Continued Stay Criteria. There are no continued stay provisions. These are time limited services; at the end of the service period, the person must meet the eligibility criteria for further services. If the person does not meet any eligibility criteria, (s)he will be discharged.

4. Expected Outcomes
   a. Resolution of the immediate crisis.
   b. In-depth assessment of the precipitant of the crisis which includes ongoing care planning recommendations.
   c. Linkage with appropriate mental health, health, and/or social service providers.

5. Level of Care
   a. Intensity: treatment is provided in the least restrictive setting
   b. Duration-depends on service component:
      1) initial outreach services: one face-to-face visit
      2) geriatric assessment services: no service limits; must be able to respond to all referrals within 24 hours
      3) home-based intensive services: (to be completed)

4) respite services: (to be completed)
5) hospital diversion beds: up to 5 days, excluding weekends and holidays
6) homebound in-residence services: up to 5 days for in-home services; up to 24 hours within 72 hours for in-facility services

c. Maximum number of service hours depends on service component

6. Covered services: refer to Part III

II(a): AMBULATORY CARE:

A. TIER 1A (ADULTS) BRIEF INTERVENTION

1. Population eligible for services: All adult Medicaid eligible and a portion of non-Medicaid eligibles who have a DSM IV Diagnosis and require short-term (varying intensity levels) treatment , with the intent of returning the individual to a level of pre-morbid functioning.

2. Admission Criteria:
   a. Meets criteria for a DSM IV diagnosis. Symptoms may be complicated by, but are not caused by substance intoxication and
   b. Level of functioning is mildly impaired (Axis V GAF < or = 70 or equivalent functioning level on a universal level of functioning tool and slight impairment on at least one PSS symptom or functioning item) and one of the following :

      1) Individual is exhibiting significantly reduced levels of functioning and/or subjective distress in response to an acute precipitating event or
      2) Individual is exhibiting symptoms of a psychiatric disturbance, representing a discrete period of illness, associated with subjective distress and/or reduced levels of functioning

3. Expected Outcome(s)
   a. Symptom resolution/reduction
   b. At a minimum, LOF is at pre-morbid level
   c. Maintain or acquire (thru linkage) Environmental Supports, if needed
   d. Prevent hospitalization, incarceration, out of home placement
   e. Prevent violent episodes against persons and property

4. Level of care
   a. Intensity: should vary depending on needs of the individual
   b. Duration: for each episode of care, within six months
   c. Maximum number of annual standardized service hours: < 15

5. Covered Services: Services can be delivered, based on clinical judgment, service recipient preference, and service recipient capability, either in or out of the mental health facility as per Part III.

B. TIER 1B (ADULTS) AFTERCARE

1. Population Eligible for Services: All Medicaid eligible and a portion of non-Medicaid eligibles who have a DSM IV diagnosis and require low intensity long-term treatment or custodial services with the intent of maintaining a safe and stable level of functioning.

2. Admission Criteria:
   a. Meets criteria for a DSM IV diagnosis. Life threatening symptoms are absent. Symptoms may be complicated by, but are not caused by substance intoxication; and
   b. Level of functioning is mildly impaired (Axis V GAF < or = 70 or equivalent functioning level on a universal level of functioning tool and slight impairment on some PSS symptom and functioning items); and
   c. The individual requires ongoing medication management because of one of the following:

      1) Individual has received maximum benefit from Tier 2 and/or Tier 3 levels of care and a lower level of care is required to sustain gains from previous treatment and prevent relapse, or
      2) Individual presents with signs and symptoms indicative of a partial remission or residual state of a serious psychiatric illness (e.g. schizophrenia, major depression), with significant potential for serious regression to an active state of illness, or
      3) There are pervasive patterns of maladaptive traits and/or behaviors, characteristics of the patient's current and long-term functioning, which result in subjective distress and/or social/occupational impairment, or
      4) There are significant disturbances in cognitive, language, motor and/or social interaction skills, associated with maladaptive functioning and/or subjective distress, or

   d. Level of function is mildly impaired (Axis V GAF > 70, and slight impairment on at least one PSS symtom and functioning item), and

      1) Individual has received maximum benefit from Tier 2 and/or Tier 3 levels of care and treatment history demonstrates that services are required to sustain gains from previous treatment and prevent relapse, or
      2) Individual presents with signs and symptoms indicative of a partial remission or residual state of a serious psychiatric illness (e.g. schizophrenia, major depression), with treatment history indicating significant potential for serious regression to an active state of illness.

3. Expected Outcome(s)
   a. No symptom increase
   b. Maintain LOF
   c. Maintain interaction with at least one person other than the case manager or parent for emotional support and companionship, if indicated by the Individual Treatment Plan
   d. Maintain participation in community events and/or day activities, if indicated by the Individual Treatment Plan.

4. Level of Care
   a. Intensity: should vary depending on needs of the individual.
   b. Duration: maintenance = indefinite, annual re authorization.
   c. Maximum number of annual standardized service hours: < 15.

5. Covered Services: Services can be delivered, based on clinical judgment, service recipient preference, and service recipient capability, either in or out of the mental health facility as per Part III. The service to be provided is medication management. If case management is indicated, the need is sporadic and very time limited. Individuals who need more regular case management should be served through Tier 2A.

C. TIER 2A (ADULTS) BRIEF INTENSIVE

1. Population eligible for services: All adult Medicaid eligible and a portion of non-Medicaid eligibles who have DSM IV diagnosis and require extended intensive and comprehensive treatment and supports to avoid hospitalization or incarceration. The duration and intensity of the intervention goes beyond limits of long term rehabilitation.

2. Admission Criteria:

   a. Individual has an active DSM IV diagnosis and
   b. Individual has recently been identified in need of mental health services and admitted into care or has been served in a less intensive care level and
   c. Level of functioning is significantly impaired (Axis V GAF of < 31 and > 10 or an equivalent functioning level on a universal level of functioning tool and marked impairment on the PSS) and
   d. Individual exhibits specific overt symptoms which require symptom-specific intervention, and
   e. Behavior is considerably influenced by delusions or hallucinations or there is serious impairment in communication or judgment, and
   f. One of the following:

      1) When provided, prior outpatient services have demonstrated a decrease in symptoms and/or an increase in functioning, or
      2) Intensive transitional treatment is required to facilitate the return to community living following an episode of acute inpatient care, or
      3) In the absence of active treatment the individual would require more restrictive alternatives.

3. Expected Outcome(s)
   a. Symptoms resolution/reduction
   b. Increased LOF
   c. Maintain or acquire (thru linkage) Environmental Supports
   d. Prevent hospitalization, incarceration, out of home placement
   e. Prevent violent episodes against person or property

4. Level of Care
   a. Intensity: at least 24 hours of treatment per week (non standardized) in the first three weeks followed by declining intensity for the next six weeks.
   b. Duration: up to 3 months.
   c. Maximum number of standardized service hours: at least 15 but < 50.

5. Covered Services: Services can be delivered, based on clinical judgment, service recipient preference, and service recipient capablitlity, either in or out of the mental health facility as per Part III.

D. TIER 2B (ADULTS) MAINTENANCE

1. Population eligible for services: All adult Medicaid eligible and a portion of non-Medicaid eligibles who have a DSM IV diagnosis and require long-term treatment or custodial services at an intensity greater than Tier 1, with the intent of monitoring client status and maintaining a safe and stable level of functioning.

2. Admission Criteria:
   a. Meets criteria for a DSM IV diagnosis. Life threatening symptoms are absent. Symptoms may be complicated by, but are not caused by substance intoxication and
   b. Level of functioning is mildly impaired (Axis V GAF $<$ or $=$70 or equivalent functioning level on a universal level of functioning tools and slight impairment in at least one PSS symptom and functioning item) and one of the following :
      1) Individual has received maximum benefit from higher Tier 2 and/or Tier 3 levels of care and treatment history indicates that low level treatment service in addition to medication support is required to sustain gains from previous treatment and prevent relapse or
      2) Individual presents with signs and symptoms indicative of a partial remission or residual state of a psychiatric illness (e.g. schizophrenia, major depression), with treatment history indicating significant potential for serious regression to an active state of illness unless low level treatment services are provided in addition to medication support.

3. Expected Outcome(s)
   a. No symptom increase
   b. Maintain LOF
   c. Maintain interaction with at least one person other than the case manager or parent for emotional support and companionship as indicated on the Individual Treatment Plan
   d. Maintain participation in community events and/or day activities, as indicated on the Individual Treatment Plan

4. Level of Care
   a. Intensity: should vary depending on needs of the individual
   b. Duration: maintenance = indefinite, annual re-authorization
   c. Maximum number of annual standardized service hours; at least 15 but $<$ 50

5. Covered Services: Services can be delivered, based on clinical judgment service recipient preference, and service recipient capability, either in or out of the mental health facility as per Part III.

E. TIER 2C (ADULTS) SHORT TERM REHABILITATION

1. Population eligible for services: All adult Medicaid eligible and a portion of non-Medicaid eligibles who have a DSM IV diagnosis and require extended treatment and community support to acquire or re-acquire skills or to maximize existing functioning that allow(s) them to live in the community (i.e. in a living situation other than a hospital, jail or prison), as independently as possible.

2. Admission Criteria:
   a. Individual has an active DSM IV diagnosis, and
   b. The individual exhibits residual symptoms which require extended treatment to acquire or re-acquire or maximize functional adaptive behavior. The individual Treatment Plan indicates specific skills or behavior changes that are to be the focus of treatment, and
   c. Level of functioning is poor (Axis V GAF of <60 and > 30 or an equivalent functioning level on a universal level of functioning tool, and marked impairment on at least one PSS symptom or functional item), and
   d. The treatment plan has specific goals and allows for gradual transition to less intensive levels of care as treatment goals are met, and.
   e. Continued stay requires demonstrated progress on skill building or behavior change.

3. Expected Outcome(s):
   a. Reduction of symptomology
   b. Increased LOF
   c. Acquire or maintain Environmental Supports
   d. Acquire or maintain Social & Personal Support Systems

4. Level of Care:
   a. Intensity: vary according to needs.
   b. Duration: short term rehabilitation up to 6 months
   c. maximum number of standardized service hours: at least 50 but < 80

5. Covered Services: Services can be delivered, based on clinical judgment and service recipient preference, and service recipient capabitlity, either in or out of the mental health facility as per Part III.

F. TIER 3A (ADULTS) INTENSIVE/LONG TERM REHABILITATION

1. Population eligible for services: All adult Medicaid eligibles and a portion of non-Medicaid eligibles who have a DSM IV diagnosis and require extended treatment and community support to acquire or re-acquire skills or to maximize existing functioning that allow(s) them to live in the community (i.e. in a living situation other than a hospital, jail or prison), as independently as possible.

2. Admission Criteria:
   a. Individual has an active DSM IV diagnosis, and
   b. The individual exhibits residual symptoms which require extended treatment to acquire or re-acquire or maximize functional adaptive behavior.[1] The Individual Treatment Plan indicates specific skills or behavior changes that are to be the focus of treatment, and
   c. Level of functioning is poor (Axis V GAF of <60 and >30 or an equivalent functioning level on a universal level of functioning tool, and marked impairment on at least one PSS symptom and functioning item), and
   d. Marked symptoms are present which diminish community functioning, or socially difficult behavior, and

[1] Reduction of overt symptoms has occurred to the degree that a less intensive level of care is indicated.

e. The treatment plan has specific goals and allows for gradual transition to less intensive levels of care as treatment goals are met, and
f. Continued stay requires demonstrated progress on skill building or behavior change.

3. Expected Outcome(s):
   a. Reduction of symptomology
   b. Increased LOF
   c. Acquire Environmental Supports
   d. Acquire Social & Personal Support Systems
   e. Prevent hospitalization, incarceration, out of home placement
   f. Prevent violent episodes against person or property

4. Level of Care:
   a. Intensity: vary according to needs
   b. Duration: 9 months
   c. Maximum number of annual standardized service hours: at least 80 but < 200

5. Covered Services: Services can be delivered, based on clinical judgment, service recipient preference, and service recipient capability, either in or out of the mental health facility as per Part III.

G. TIER 3B EXCEPTIONAL CARE

1. Population eligible for services: All Medicaid eligibles and a portion of non-Medicaid [1]eligibles who have a DSM IV diagnosis and require extended intensive and comprehensive treatment and supports to avoid hospitalization or incarceration. The duration and intensity of the intervention goes beyond limits of Intensive Long Term Rehabilitation.

2. Admission Criteria:
   a. Individual has an active DSM IV diagnosis, and
   b. Individual has recently been identified in need of mental health services and admitted into care, and
   c. Level of functioning is significantly impaired (Axis V GAF of <31 and >10 or an equivalent functioning level on a universal level of functioning tool marked impairment or at least one PSS symptom and most PSS functioning items), and
   d. Individual exhibits specific overt symptoms which requires symptom-specific intervention, and
   e. Behavior is considerably influenced by delusions or hallucinations or there is serious impairment in communication or judgment or inability to function in almost all areas, and
   f. Prior treatment history indicates that brief intensive services have not been of sufficient duration to stabilize the individual, and
   g. One of the following:
      1) When provided, prior outpatient services have demonstrated an increase in functioning, or
      2) Intensive transitional treatment is required to facilitate the return to community living following an episode of acute inpatient care, or
      3) In the absence of active treatment the individual would require more restrictive alternatives, or

1

3. Expected Outcome(s):
   a. Reduction of overt symptoms to a degree that the individual can avoid hospitalization or inappropriate incarceration and receive active treatment at a less intensive level of care.
   b. Prevention of violent episodes against person or property.

4. Level of Care:
   a. Intensity: should vary depending on the needs of the individual and as established in the exceptional care plan
   b. Duration: up to 12 months
   c. Maximum number of annual standardized service hours: at least 200, as established in the exceptional care plan.

5. Covered Services: Services can be delivered, based on clinical judgment and service recipient preference, either in or out of the mental health facility as per Part III.II(b).

H. INTENSIVE RESIDENTIAL SERVICES

1. Population eligible for services: All Medicaid eligible individuals who have a DSM IV diagnosis and require extended intensive and comprehensive treatment and 24-hour supervision to protect the safety of self and others, to avoid hospitalization or incarceration, and/or to maximize functional ability.

2. Admission Criteria:
   a. the individual has an active DSM IV diagnosis, and
   b. the individual exhibits symptoms and behaviors which are incompatible with safety in less supervised or independent community living situations, and
   c. the individual has a severely impaired level of functioning (Axis V GAF of < 11 or an equivalent level of functioning on a universal level of functioning too, and severe impairment on on at least one PSS symptom and most PSS functioning, items), and
   d. for admission, priority will be given to individuals being discharged from Western State Hospital.

3. Expected Outcomes:
   a. safety of self and others
   b. symptom stabilization/reduction
   c. progress on goals identified in the Individual Treatment Plan
   d. prevent hospitalization or incarceration
   e. maximized functional ability

4. Length of Care
   a. Intensity: 24 hour intensive residential
   b. Duration: indefinite, annual re authorization

5. Covered Services: All board, domiciliary, and treatment services are provided and included within the scope of the 24 hour supervised care setting.

AMBULATORY CARE: CHILDREN

Ia). ACUTE CARE - INPATIENT: CHILDREN

A. ACUTE VOLUNTARY PSYCHIATRIC INPATIENT CARE

1. Admission Criteria
   a. A DSM IV diagnosis and a CGAS < 40.
   b. A psychiatric condition which requires 24-hour medical/psychiatric and nursing services and is of an intensity such that care can be appropriately provided only at an acute level of hospital care; and
   c. Services in an acute care facility can reasonably be expected to significantly improve the patient's psychiatric condition within a short period of time so that 24-hour inpatient medical/psychiatric and nursing services will no longer be needed; and
   d. There is a plan of treatment, discharge and follow-up care which is specific to the psychiatric symptoms which precipitated acute inpatient psychiatric treatment.

2. Continued Stay Criteria
   All of the above criteria continue to be met.

B. ACUTE INVOLUNTARY PSYCHIATRIC INPATIENT CARE (for children 13 years and older)

1. Admission Criteria
   a. Face to face evaluation by a CDMHP; and
   b. Criteria for involuntary detention/commitment under RCW 71.05 have been met; and
   c. All appropriate and available less-restrictive treatment options, including voluntary hospitalization, have been ruled out following consultation with the assigned primary outpatient care provider; or
   d. A commitment decision has been made by the Superior Court.

2. Continued Stay Criteria
   a. The patient's psychiatric condition continues to require 24-hour medical/psychiatric and nursing services and is of an intensity such that care can be appropriately provided only at an acute level of hospital care; and
   b. The patient is unable or unwilling, in good faith, to abide by the admission conditions of a voluntary hospitalization; or
   c. The length of stay has been extended due to court processes.

C. CRISIS ALTERNATIVE SERVICES

1. Population eligible for services: All persons aged under 18 for whom a mental disorder cannot be ruled out and who are in need of crisis/emergency services to prevent imminent hospitalization or incarceration, harm to self or others or serious decrement in functioning leading to long-term disability.

2. Admission Criteria
   a. Initial crisis outreach:

      1) All population-eligibles, AND to be developed

3. Continued Stay Criteria. There are no continued stay provisions. These are time limited services; at the end of the service period, the person must meet the eligibility criteria for further services. If the person does not meet any eligibility criteria, (s)he will be discharged.

4. Expected Outcomes
   a. Resolution of the immediate crisis.
   b. In-depth assessment of the precipitant of the crisis which includes ongoing care planning recommendations.
   c. linkage with appropriate mental health, health and/or social service providers

D. TIER 1A (CHILDREN) BRIEF

1. **Population Eligible for Services:**
All Medicaid child and adolescent recipients who have a DSM IV diagnosis for which it is a medical necessity to provide an intervention and that intervention can reasonably be expected to be effective at a level that is short term and of low to moderate intensity.

2. Admission Criteria:
   a. Diagnosis

      Meets criteria for a DSM IV diagnosis that causes significant distress or that interferes with the ability to fully function in the normal spheres of life although some degree of functioning is maintained. Symptoms may be complicated by, but are not caused by substance intoxication and

   b. Level of Functioning

      Level of functioning on Axis V CGAS <or=70* or three or more "major features items" on the Behavior Rating Scale** and

*For purposes of assessment the Children's Global Assessment Scale (CGAS) need not be used for children under the age of 6. Disregard the CGAS criteria for this population
**Behavior Rating Scale refers to *question 8* on the EPSDT Assessment Form.

3. Expected Outcome(s)
   a. Symptom Resolution

      Symptoms of the DSM IV diagnosis will be resolved or be reduced to a level that does not interfere with functioning.

   b. Level of Functioning

      Functioning ability will be maximized within the limits of a short-term, minimum to moderate intensity intervention, but sufficiently to assure adequate ability to function at home, in school and in the community at or near per morbid level of functioning.

   c. Family/Environmental Supports

      Family functioning (or long term placement functioning) will be assured so as to restore/maintain a nurturing environment.

d. Placement Preservation

The intervention will have prevented an out of home placement, placement disruption, incarceration, or hospitalization.

4. Level of care

a. Intensity

Will vary between low and moderate depending on the needs of the individual.

b. Focus of Intervention

The client qualifies for services at this service level even if it is anticipated that some of the benefit may be best used in collateral contacts such as with parents or other caretakers, schools, or with other service providers.

c. Duration

Less then or equal to 6 months

d. Hours

The maximum number of standardized service hours is <15.

E. TIER 1B (CHILDREN) AFTERCARE THERAPY

1. Population Eligible for Services: Those who have received Long Term or Brief Intensive Treatment, Short or Long Term Rehabilitation, or Exceptional Care services. All Medicaid eligible children and a portion of non-Medicaid eligibles who have a DSM-IV diagnosis and require low intensity long-term treatment to maintain gains from other services and to help adjust to the community intent of maintaining a safe and stable level of functioning.

2. Admission Criteria:

a. Diagnosis/Treatment History.

Meets criteria for a DSM IV diagnosis and has participated in a higher level of service.

b. Level of Functioning

Level of functioning on xis V CGAS $<$ or $=$ 70 or is under 6 years of age and one of the following, either:

1) Individual has received maximum benefit from a higher level of service (brief intensive or short-term rehab) but treatment history and the individual's residual difficulties indicates maintaining gains or continued improvement is clinically feasible, but will require, long-term follow-up at minimal intensity level, or

2) Individual has received maximum benefit from a higher level of service but family and social supports remain inadequate so as to make maintaining gains, preventing relapse and continued improvement feasible only with long-term supportive follow-up at minimal intensity, or

3) Individual presents with signs and symptoms indicative of partial remission of a serious and persistent psychiatric illness (e.g. schizophrenia, bipolar illness, major depression), with treatment history indicating significant potential for serious regression to an active state of illness and minimal level of service is either assessed as clinical efficacious or the individual is unwilling to accept a higher level of service.

3. Expected Outcome(s)

a. Symptom Resolution

Symptoms of DSM IV diagnosis will not increase or worsen.

b. Level of Functioning

Functioning will be at least maintained at the level achieved in more active treatment.

c. Family/Environmental Supports

Family functioning (or stability of long-term placement) will be maintained, relationships with caretakers will continue to strengthen and the individual will maintain or develop sufficient social supports to allow for psychological growth and development at least within the limits of their capabilities given any residual symptoms or signs of persisting pscychopathology.

4. Level of Care

a. Intensity

Low

b. Focus of Intervention

Either child directly or family or social support system.

c. Duration

Indefinite, presumed long-term follow-up care but may vary depending on needs of the individual, annual re authorization required.

d. Hours

Maximum number of standardized service hours: < 15

G. TIER 2A (CHILDREN) BRIEF INTENSIVE

1. Population eligible for services: All Medicaid eligible children and a portion of non-Medicaid eligibles who have DSM IV diagnosis and require extended intensive and comprehensive treatment and supports to avoid hospitalization or incarceration. The duration and intensity of the intervention goes beyond limits of long term rehabilitation.

2. Admission Criteria:

a. Diagnosis

Meets criteria for a DSM IV diagnosis that causes significant distress or that interferes with the ability to function adequately in most of the normal spheres of life. Symptoms may be complimented but are not caused by substance intoxication, and

b. Level of Functioning

The pre morbid functioning was adequate (CGAS > 60 for children over 6 yrs.) and the level of functioning is strikingly impaired on current assessment (must be at least CGAS < 60 for children over 6 yrs. or five "major feature items" on the Behavior Rating Scale**) and

c. Social Supports

The client has a family which is either

1) willing and able to utilize treatment, or
2) able to mobilize supports within the extended family which can assure utilization of the treatment, or
3) the child has been placed in a stable alternative living situation which is willing and able to support treatment

and the problem is either an

d. Acute Crisis

The client presents with a crisis which has a clear beginning within the past 6 mo., either

1) a sudden onset of symptoms which interfere with the individual's functioning (>20 drop in CGAS) either independent of environmental stressors, or the result of a discrete trauma which has impacted child's psychological adjustment and functioning, or

2) in the case of children under 6, the result of a developmental crisis which the parents are unable to handle that attends to the needs of the child, leading to symptoms of a DSM IV disorder in the child causing increased parental distress, leading to further decrease in the families functioning.

or an

e. Acute Exacerbation

The client presents with an acute exacerbation of a previous mental health problem which

1) had been in stable remission for at least one year without significant functional impairment, and
2) required no mental health treatment during the previous year, and
3) has recurred within the previous 3 months, and

4) has caused a significant reduction in functioning (at least a drop in CGAS of >20 in children over 6) and

f. Systems Issues and Risks

The child is involved in at least one of the following:

1) imminent risk of out of home placement, or disruption of previously stable placement, or
2) juvenile court involvement with recommendation or referral for structured mental health treatment, or
3) school difficulties such that:

(a) child is imminently at risk of long-term suspension or expulsion from current school placement, and
(b) is required by the school to be in structured mental health treatment as a condition of continued school placement

or

4) child's mental health problems and their functional consequences in the community require significant inter system coordination

3. Expected Outcome(s):

a. Symptom Resolution

Symptoms of current DSM IV diagnosis will resolve or deminish to a degree as to be functionally insignificant and manageable with no greater then non-intensive aftercare services.

b. Level of Functioning

Level of functioning will return to near pre morbid level and will be sufficiently improved to assure adequate functioning in the home, school, and the community.

c. Family/Environmental Supports

Family functioning (or long term placement functioning) will be assured so as to restore/maintain a nurturing environment and necessary social and family supports will be in place through system linkages so as to assure continued functioning.

d. Placement Preservation

The intervention will have prevented an out of home placement, placement disruption incarceration of hospitalization.

4. Level of care:

a. Intensity

Will vary between moderate and intensive depending on the needs of the individual.

b. Focus of the Intervention

The client qualifies for services at this service level even if it is anticipated that some of the benefit may be best used in collateral contacts such as with parents or other caretakers, schools, or with other service providers.

c. Duration

For each treatment episode, 3 mo.

d. Hours

Authorized for > 15, < 50 with re-authorization possible for and additional 30.

F. TIER 2B (CHILDREN) LONG TERM TREATMENT

1. Population eligible for services: All Medicaid eligible children and a portion of non-Medicaid eligibles who have a DSM IV diagnosis and require long-term treatment or support services at an intensity greater than Tier 1, with the intent of monitoring client status and maintaining a safe and stable level of functioning, promoting healthy psychological development and providing a treatment context to guide the resolution of symptoms of their diagnosis.

2. Admission Criteria:

a. Diagnosis

Meets criteria for DSM IV diagnosis, and

b. Level of Functioning

Level of functioning may vary greatly but is at least mildly impaired with a CGAS for children of 6 of < 70, and

c. Duration of Condition

Symptoms of the diagnosis have persisted over a significant period of time (>1 yr. for children 11 yr. or more; >6 mo. for children 6-10; and >3 mo. for children 5 and younger) and these symptoms interfere with the child's functioning or their healthy psychological development, and either:

1) Some symptom indicative of a lifelong mental illness can be documented by history as having been present since the first four years of life or for over half the child's life, or

2) A history of severe traumas or a pattern of traumatizing conditions can be documented since the first four years of life, or for over half the child's life, or

3) The child's family and social environment is severely and chronically dysfunctional (since first four years of life, or for over half the child's life), this dysfunction has causes or has been the largest contributing factor to the child's DSM IV diagnosis, and the family and social dysfunction has not responded to prior intervention attempts.

and

b. Conditions, Circumstances and other Factors

The child must have at least two of the following factors currently effecting his/her situation:

1) One item present form the following list of Conditions Impacting Child's Behavior, either:

(a) disabling medical condition, or
(b) neurological impairment including fetal drug/alcohol effected, traumatic brain injury or malnutrition, or
(c) attachment disorder issue currently which originate from behaviors/traumas before age 5, or
(d) DSM IV Axis II developmental disorder, or
(e) learning disability and/or educational assessment designating child Seriously Behaviorally Disturbed, or
(f) alcohol/substance abuse in child, or
(g) law breaking behavior (either adjudicated or by history)

and/or

2) Two items from the "Circumstances Impacting Child's Behavior" list from the EPSDT Assessment Form plus the following additional items, either:

(a) cognitive impairment of parents, and/or
(b) poor family coping/parenting skills, and/or
(c) more then 3 moves in the last 1 year, and/or
(d) 1 out-of-home placement of >1 week in last year, and/or
(e) has been homeless within the last year, and/or
(f) serious parent child conflict, and/or
(g) cultural/sexual minority context exacerbates problems

and/or

3) Previous less intensive or brief services have not been sufficiently helpful to stabilize child. Such services include:

(a) school services alone, and/or
(b) court services alone, and/or
(c) social services, including Family Reconciliation Services, alone, and/or
(d) all services; out-patient, in-home, social or mental health, with time limits of >15 hrs. within 1 yr., and/or
(e) psychiatric medications only with medication management follow-up care.

and/or

4) Previous more intensive services received within the past 1 yr. has not resolved problems sufficiently to allow Tier 1B follow-up care, Such services include:

(a) day treatment and partial hospitalization, and/or
(b) intensive community support services, and/or
(c) CHAPS/treatment foster care, and/or
(d) group home placement or residential treatment, and/or
(e) psychiatric hospitalization, and/or
(f) Interagency Staffing Team involvement.

and/or

5) CGAS < 50

3. Expected Outcome(s)

a. Symptom Resolution

Symptom severity deminished over 1 yr. for active symptoms with maintenance of symptom resolution for previously resolved symptoms. Symptoms will not interfere with health psychological development including expansion and deepening of important relationships.

b. Level of Functioning

Level of functioning will be improved over one year as measured by one of the following, either:

1) Increase in CGAS, or
2) Improved relationships within family / if history of placement disruptions, ability to maintain stable placement, or
3) Improved performance academically / if history of school disruptions, ability to maintain stable placement in school, or
4) Develop and maintain participation in age appropriate activities, or
5) Develop and maintain healthy peer relationships, or
6) if involved with Juvenile Court, decrease involvement

4. Level of care

a. Intensity

should vary low to moderate depending on needs of the individual.

b. Focus of Intervention

Either individual, family or social/care system, in or out of facility depending on needs of the client and clinical judgment. May vary over time.

c. Duration

Indefinite, presumed long-term relationship based care but may vary depending on needs of individual, annual re authorization required.

d. Hours

Number of annual standardized service hours; at least 15 but < 50.

H. TIER 2C (CHILDREN) SHORT TERM REHABILITATION

1. Population eligible for services: All Medicaid eligible children and a portion of non-Medicaid eligibles who have a DSM IV diagnosis and require extended treatment and community support to acquire or re-acquire skills or to maximize existing functioning that allows them to live in the community (i.e. in a living situation other than a hospital, residential or group care).

2. Admission Criteria:

   a. Diagnosis/Duration of Symptoms

   Meets criteria for a DSM IV diagnosis and symptoms of this diagnosis have persisted over a significant duration (> or = 1 yr. for children over 11 yrs., > or = 6 mo. for children 6 - 10 yrs., and > or = 3 mo. for children 5 yrs. or younger) and has not resolved with prior conservative treatment, and

   b. Level of Functioning

   Level of functioning has been severely effected by the symptoms of the diagnosis (CGAS < or = 50 for children over 6) and this dysfunction has persisted despite prior more conservative treatment and the nature of the functional impairment appears to be amenable to change with a short-term rehabilitation intervention (6 mo. or less), and

   c. Conditions and Circumstances

   The child must have at least two of the following circumstances currently effecting his/her situation, either

   1) one of the following conditions:

      (a) disabling medical condition, or
      (b) neurological impairment including fetal alcohol or drug effects, traumatic brain damage, impairments due to malnutrition, or
      (c) attachment disorder issues currently which originate from behaviors/traumas apparent before age 5, or
      (d) developmental disorder including Pervasive Developmental Disorder, and severe learning disorders, or
      (e) has been found on IEP to have Serious Behavior Disorder, or
      (f) significant alcohol or substance abuse problem causing dysfunction at home, at school, or in the community, or
      (g) delinquency either adjudicated or positive history of delinquent behavior.

   and/or

   2) Two of the following circumstances.

      (a) parents have cognitive impairments, and/or
      (b) poor family coping/parenting skills, and/or
      (c) more then 3 moves in past year, and/or
      (d) at least one out of home placement in past year, and/or

(e) has been homeless within last year, and/or
(f) serious parent/child conflict, and/or
(g) seriousness of child's symptoms/functioning is exacerbated by their presence within a cultural/sexual minority context.

and/or

3) Child has received at least 1 "more intensive services" in the past 1 yr. defined as:

(a) day treatment, or
(b) intensive community support services, or
(c) CHAPS/treatment foster care, or
(d) consideration by the interagency staffing team, or
(e) group or residential placement, or
(f) psychiatric hospitalization

and/or

4) CGAS < or = 50

3. Expected Outcome(s):

a. **Symptom Resolution**

Symptoms of the DSM IV diagnosis will be resolved or reduced to a level which does not preclude functioning in the community and will allow the child to resume developing psychologically.

b. **Level of Functioning**

Level of functioning will be increased to or near pre morbid level sufficiently to allow the child to function at home, school, and in the community with only non-intensive aftercare and supports acquired or re-acquired from other systems and from the community.

4. Level of care

a. **Intensity**

Moderate to high

b. **Focus of Intervention**

The intervention may involve the child, his/her family and others in the child's social and caretaking environment, either in or out of facility, but primarily focused on building skills sufficient within the time frame to enable the child to function and be self sustaining at home, at school, and in the community.

c. **Duration**

6 months

d. **Hours**

Greater or equal to 50 but less then 80 hours

I. TIER 3A (CHILDREN'S) INTENSIVE/LONG TERM REHABILITATION

1. Population eligible for services: All Medicaid eligibles children and a portion of non-Medicaid eligibles who have a DSM IV diagnosis and require extended treatment and community support to acquire or re-acquire skills or to maximize existing functioning that allow(s) them to live in the community.

2. Admission and Continued Stay Criteria:

- Meets criteria for Tier II (does not need to meet duration criteria)

AND

- <= 40 on CGAS (For children 6 and above)

AND at least one of the following starred items:

- Acute crisis with imminent risk of placement. The child is demonstrating unusually reckless behavior, aggression, self injurious behavior or extremely poor judgment.
- One inpatient psychiatric hospitalization in the last year
- More than one therapeutic out-of-home placement in the last year (i.e. CHAPS/treatment foster care, residential group care)
- Multiple foster placements or placements with relatives or other supports (3 or more in last 2 years)

For children under the age of six, signs of seriousness are atypical behavioral, socio-emotional, motor or sensory development as manifested by one of the following:

- Delay or abnormality in achieving expected emotional milestones, such as: pleasurable interest in adults and peers; ability to communicate emotional needs; and ability to tolerate frustration;
- Persistent failure to initiate or respond to most social interactions;
- Fearfulness or other distress that does not respond to comfort by caregivers;
- Indiscriminate sociability, e.g. excessive familiarity with relative strangers;
- Self injurious or unusual aggressive behavior.

3. Expected Outcome(s): Development of the highest level of adaptive functioning which can be expected given the nature and course of the youth's disorder.

4. Level of care:
   a. intensity: vary according to needs
   b. duration: 1 year
   c. maximum number of annual standardized service hours: at least 80 but < 200

5. Covered Services: Services can be delivered, based on clinical judgment and/or service recipient preference, either in or out of the mental health facility as per Part III.

J. TIER 3B (CHILDREN) EXCEPTIONAL CARE

1. Population eligible for services: All Medicaid eligible children and a portion of non-Medicaid eligibles who have a DSM-III-R diagnosis and require extended intensive and comprehensive treatment and supports to avoid hospitalization or incarceration. The duration and intensity of the intervention goes beyond limits of Intensive Long Term Rehabilitation.

2. Admission Criteria:
   a. Youth has an active DSM-III-R diagnosis and
   b. Youth has recently been identified in need of mental health services and admitted into care.
   c. Treatment will be decided on an youth basis according to need.

3. Expected Outcome(s):
   Reduction of overt symptoms to a degree that the youth can avoid hospitalization or inappropriate incarceration and receive active treatment at a less intensive level of care.

4. Level of care
   a. Intensity: should vary depending on the needs of the youth and as established in the exceptional care plan
   b. Duration: up to 12 months
   c. Maximum number of annual standardized service hours: at least 200, as established in the exceptional care plan.

5. Covered Services: Services can be delivered, based on clinical judgment and service recipient preference, either in or out of the mental health facility as per Part III.II(b).

PART III

Care Covered Services: Adults

ADJUNCT SERVICES	
RSN ACCESS	
- 1 800 Access for Information and Referral	Universal Benefit
- Initial Screening and Service Linkage	Universal Benefit
- Language Interpretation	Universal Benefit
- Medical Assessment for Entitlements, Courts	Universal Benefit
RSN ACUTE CARE	
A. ACUTE VOLUNTARY INPATIENT	CA
B. ACUTE INVOLUNTARY INPATIENT	CA
C. CRISIS ALTERNATIVE SERVICES	
- Cultural Assessment	CA
- Emergency Medication Purchase Assistance	CA
- Geriatric Assessment Services	CA
- Homebound In-Residence Services	CA
- Hospital Diversion Beds	CA
- In-Home Crisis Stabilization	CA
- Initial Outreach Services	Universal Benefit
- Respite	CA
RSN RESIDENTIAL , Board and Domiciliary Portion	CA

Care Covered Services: Children

ADJUNCT SERVICES	
RSN ACCESS	
- 1 800 Access for Information and Referral	Universal Benefit
- Initial Screening and Service Linkage	Universal Benefit
- Language Interpretation	Universal Benefit
- Medical Assessment for Entitlements, Courts	Universal Benefit
RSN ACUTE CARE	
A. ACUTE VOLUNTARY INPATIENT	CA
B. ACUTE INVOLUNTARY INPATIENT	CA
C. CRISIS ALTERNATIVE SERVICES	CA
- Cultural Assessment	CA
- Hospital Diversion Beds	CA
- In-Home Crisis Stabilization	CA
- Initial Outreach Services	Universal Benefit
- Respite	CA

RSN/PHP AMBULATORY CARE, COVERED SERVICES, CHILDREN AND ADULTS	STANDARDIZATION OF SERVICE HOURS (SSH)
- Adult Acute Diversion	2:1
- Adult Day Treatment	6:1
- Child and Adolescent Acute Diversion	2:1
- Child and Adolescent Day Treatment	3:1
- Clubhouse	12:1
- Crisis	1:1
- Critical Mental Health Services	1:15
- Cultural Assessment	1:1
- Drop-In Center	15:1
- Family Therapy	1:1
- Group Treatment Services	6:1
- Individual Treatment Services (Case Management, brief therapy, clinical case management)	1:1
- Intake Assessment	1:1
- Interdisciplinary Assessment	1:1
- Medical Management - Group	10:1
- Medical Management - Individual	2:1
- Partial Hospitalization	1:12
- Psychological Assessment	1:1
-Vocational Counseling	1:1

Universal Benefit = covered service that requires no authorization
CA = Covered service, per above, but additional criteria for authorization.
SSH = Standardization of service hours.

This is a list of modalities and the ratios used to standardize them. An hour of youth treatment services was used as the approximate benchmark for standardization. There was no differentiation for in facility vs. out of facility services. The ratios are applied after summing youth billing units up to an hours worth of service where service units are measured by time (for Medication Management and Critical Mental Health Services the ratio applies to each billing unit). A ratio of 2:1 means that two hours or units of the service make one standardized service hour.

PART IV

Adjunct Services: Definitions

Emergency Medication Purchasing Assistance: A service by which funding will be provided to persons already holding prescriptions for psycho tropic medications who are temporarily unable to afford those medications; vouchers will be provided by provider agencies that will have follow-up medication management responsibility.

Geriatric Assessment Services: A specialized, region wide crisis program for persons 60 years of age or older who are not currently enrolled in the mental health long term care system. The service objectives are to:

-facilitate age-appropriate assessment of service needs;
-expedite referral to the service system which will provide the most appropriate long-term care;-
prevent unnecessary involuntary hospitalizations; and
-avoid unnecessary disruptions in place of residence.

Services include interdisciplinary assessment; the development and implementation of a crisis intervention plan which includes referral and linkage to the mental health, health, and social service providers who will be providing the long-term follow-up; and support, consultation, and care planning with families or other non-professional care providers, mental health providers, aging services providers, and health care providers.

Homebound In-Residence Services: Temporary supervision, assistance with activities of daily living, and referral and linkage to other services provided in their place of residence to those adults for whom a mental disorder cannot be ruled out who are in crisis AND who are homebound because of medical, physical, cognitive and/or psychiatric disabilities and who require these services to ensure that their personal safety, or the safety of others.

Hospital Diversion Beds, Adults: A bed located in a facility which provides 24 hour staff supervision. The goal is to avert immediate voluntary or involuntary hospitalization for those persons who need very short-term supervision during times of emotional crisis in order to ensure their safety and the safety of others. The service objectives are to:

-provide a safe, supervised short-stay bed for persons in emotional crisis;
-provide further assessment of the need for psychiatric hospitalization; and
-link the person with the services needed to achieve longer term crisis resolution.

In addition to placement in the bed, services provided may include assessment for Tier placement, beginning development of a treatment plan if the person is to be served in the mental health system, and referral and linkage with other clinically indicated social and health care services.

In-Home Crisis Stabilization: Crisis-oriented services, provided on an outreach basis to work intensively with children and/or families/adults in their homes.

Initial Crisis Outreach: A service provided by the PHP seven days a week, 24 hours per day. Initial face-to-face contact for persons in crisis for whom a mental disorder cannot be ruled out is provided in community-based settings. These are one-time only contacts; if the person in crisis does not need voluntary or involuntary hospitalization but does require further services, (s)he is referred immediately to another mental health, health, or social service provider for follow-up.
Language Interpretation: A service for all persons who have contact with the RSN/PHP system who are having difficulty conversing in a common language with their treatment provider. It is a benefit for persons receiving either adjunct or ambulatory care.

Respite Services: Supervision and temporary assistance with basic needs for a person in crisis. These services are provided in the home for caregiver relief, or in a respite bed if remaining in the home is a central part of the crisis or if the person is temporarily homeless.

Ambulatory Care Covered Services: Definitions

CHAPS Foster Care: Therapeutic foster care services that include clinical case management, youth and group therapy, consultation and training to foster families. The services are time limited and the admission process is in cooperation with DCFS through an Interagency Mechanism.

Crisis Evaluation: Single face-to-face contact which involves clinical formulation of need for short term services to address the specific crisis.

Crisis Stabilization Workers: Trained staff are available within a two hour period to provide one to one supervision for children in crisis who need supervision as part of a plan to prevent placement or to maintain current placement. Services can be planned respite or as part of a crisis plan.

Clubhouse: (Adult) - Means a program intended to provide psychosocial rehabilitation services including, but not limited to: vocational, housing support, food, socialization, medication support, family and advocate support. There are regular planned and structured activities, staff facilitated, but consumer mobilized, in an environment intended to enhance consumer empowerment in determining, relieving psychosocial needs.

Cultural Assessment: An evaluation of the person and her/his environment and circumstances which is performed by a culturally competent specialist clinician to determine cultural history and cross cultural dynamics in order to adapt services to meet culturally unique needs.

Day Treatment: (Adult) - Means a program intended to provide a range and mix of planned and structured services to mentally ill persons 18 years of age and older. These services are designed to:

- maintain consumers in an environment less restrictive than an inpatient setting through structuring of day and leisure time;
- develop and maintain necessary community living and self care skills, such as: education in health and nutritional issues, personal maintenance, money management, and maintaining the living environment; developing basic language skills necessary to enable the consumer to function independently; training in appropriate use of community services; prevocational services and treatment approaches congruent with the age and cultural framework of the youth.[6]

[6] Title XIX Service Modalitites Rehabiliation Option (Effective July 1, 1991). Published by DSHS, Mental Health Division

Day Treatment (Children): Means a program intended to provide a range and mix of planned and structured services to seriously disturbed persons under the age of 18, unless a written authorization for exception is granted by the mental health division. These services are designed to:

- maintain consumers in their community, in an environment less restrictive than an inpatient or residential setting through structuring of day and leisure time;
- develop age appropriate daily living, educational and social skills to maximize the growth and developmental potential of each consumer; and
- serve as an alternative to more restrictive long-term inpatient or residential care.[7]

Drop-In Center Services: (Adult) - Means a program intended to provide limited staff support in an environment without regular planned and structured services. There are regular hours of facility availability, however, and access to attendant staff who may facilitate skilled staff contact. The primary benefit is inter consumer socialization.

Family Therapy: Face-to-face psychotherapy or counseling provided by trained qualified professionals to family members; therapy can be focused on any one or more family members; focus may be on improving family relationships and coping strategies.

Group Therapy: Face-to-face psychotherapy or counseling provided by trained qualified professionals to groups of youths who are working on commonly identified treatment goals.

Treatment Services: -Brief Therapy: Face-to-face psychotherapy or counseling provided by trained qualified professionals to youths seeking assistance in ameliorating symptoms and/or resolving problems.
-Clinical Case Management: Services include

- assessment of consumer's cognitive, emotional, or physical state in order to ascertain the need for and/or appropriate level of mental health services
- case planning in collaboration with consumers and/or family members in order to develop or update youthized service and treatment plans
- linkages with resources not provided by the mental health system
- crisis intervention services
- advocating on behalf of consumers in order to obtain necessary resources
- monitoring consumer's care in order to assure that services provided are of the appropriate level and mix
- assisting consumers to develop and maintain interpersonal relationships[8]
- working with consumer network to enhance environmental support.
- assistance in skill building in activities of daily living (e.g. grocery shopping, meal planning)
- linkages with resources not provided by the mental health system

-Case Management--Linkage and Brokerage Only: Services include

- linkages with resources not provided by the mental health system

-Vocational Counseling: Face-to-face therapy or counseling for youths seeking assistance in resolving problems regarding employment issues.

Intake/Assessment: An evaluation initiated prior to the provision of any other services, except crisis services and crisis alternative services [initial outreach services, geriatric assessment services, geriatric/homebound in residence services, home based intensive services (adult/child), hospital diversion beds]. The intake assessment must establish the medical necessity for treatment and be completed within 30 days. Intake assessment for establishment of eligibility for Tier authorization that result in no authorization are covered. Referral to providers and resources outside of the mental health system.

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[7] Ibid
[8] KCRSN Data Dictionary, Revision D, Effective October 1, 1993

Interdisciplinary Evaluation: An evaluation of the person and her/his environment and circumstances which, when clinically indicated, incorporates input from nursing, social work, medicine, psychiatry, and/or occupational therapy. The assessment is designed to:-provide differential psychiatric diagnosis;
-uncover hidden medical problems which may be contributing to disturbances in mental status;
-establish functional capability to manage activities of daily living and remain safely in a less restrictive environment; and
-establish the degree of support an assistance available from the person's social network for the proposed intervention plan.

Medication Management: Services in which psychiatric medications are prescribed, administered, and monitored by appropriately qualified, licensed professionals.

Partial Hospitalization/Acute Diversion (Adult): A separate and distinct cluster of services that occur in a group setting (e.g. day hospital) for non-enrolled as well as enrolled youths which is a less restrictive alternative to inpatient hospitalization, or is a transitional program after discharge from inpatient services. This service is designed for persons with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment, such that: [9]

a. The youth exhibits psychiatric symptoms of sufficient severity to bring about significant or profound impairment in day-to-day social, vocational and educational functioning, and
b. The youth is able to exhibit adequate control over his or her behavior and is judged not to be so immediately dangerous to self or others as to require 24 hour medical supervision. Suicidal ideas or gestures, a history of self-mutilation or self endangering behaviors and assaultive tendencies may exist but acuity falls short of inpatient criteria, and
c. The youth has the capacity for reliable attendance and active participation in all phases of the program and

d. One of the following:
   1) The youth has failed to make sufficient clinical gains within a traditional outpatient setting or has not attempted such outpatient treatment, and the severity of presenting symptoms is such that success of traditional outpatient treatment is doubtful; or
   2) The youth is ready for discharge form an inpatient setting, but it is judged to be in continued need of daily monitoring, support and ongoing therapeutic intervention.

Partial Hospitalization/Acute Diversion (Child and Adolescent): Short term, mental health services that occur in a group setting (e.g. day hospital) for non-enrolled as well as enrolled acutely mentally ill youth at immediate risk of receiving care in an inpatient unit. Services shall include an age appropriate mix of services which include social/recreational activities. Services include: stabilization of the crisis situation and maintenance of the child in the most normative, least restrictive environment possible; provision of immediate assessment of treatment needs and development of an youthized treatment and discharge plan; rebuilding developmental deficits such that the child's social, emotional and education needs are responded to; development and implementation of an after care plan. [10]

Residential, Supervised: (Adults) - Means any of those residential service programs including, but not necessarily limited to Adult Family Home, Congregate Care Facility, and where staff provide 24 hour on-site supervision. This service authorization/payment is limited to board and domiciliary care. As

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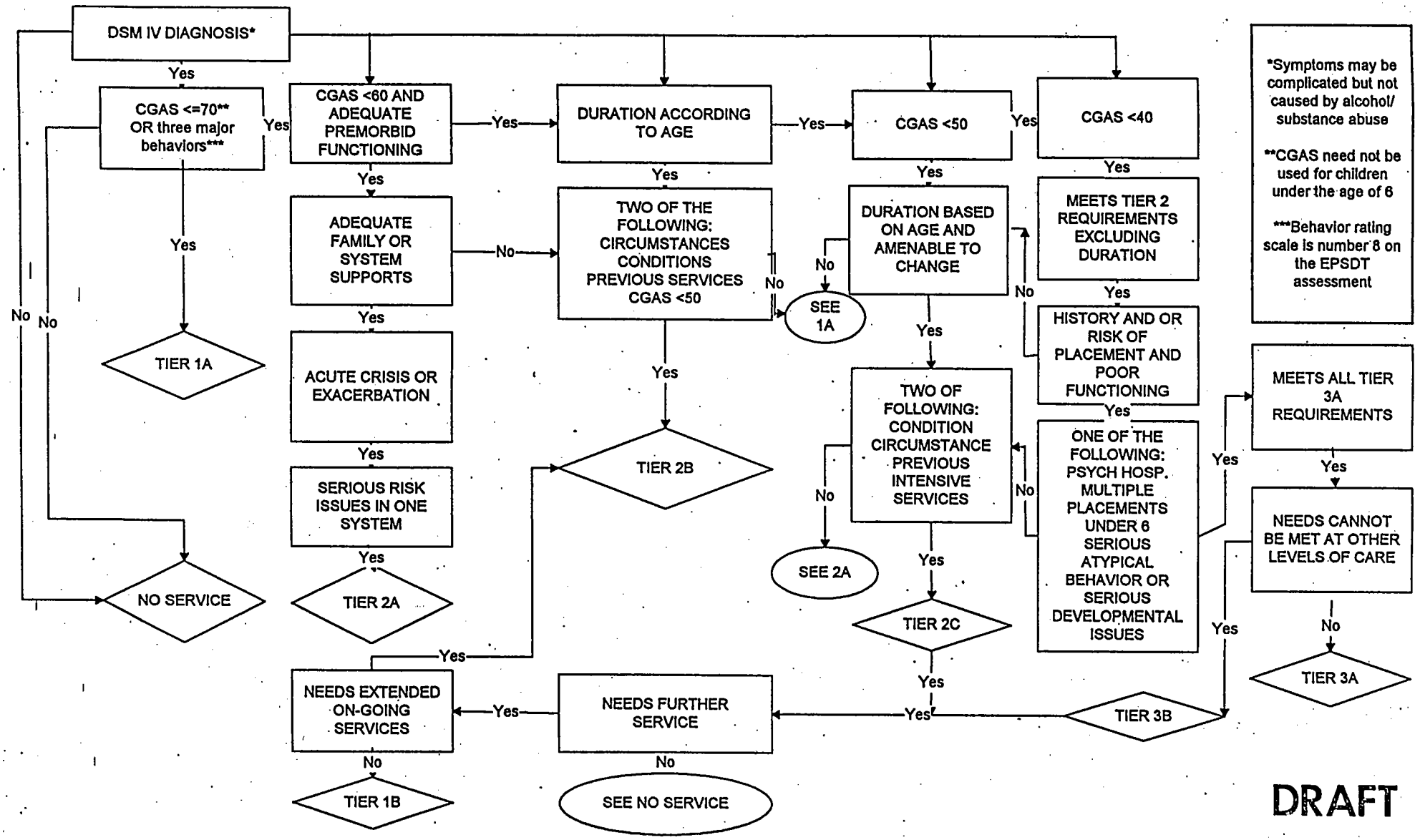
[9] Title XIX Service Modalities Rehabilitation Option (effective July 1, 1991). Published by DSHS. Mental Health Division
[10] Ibid

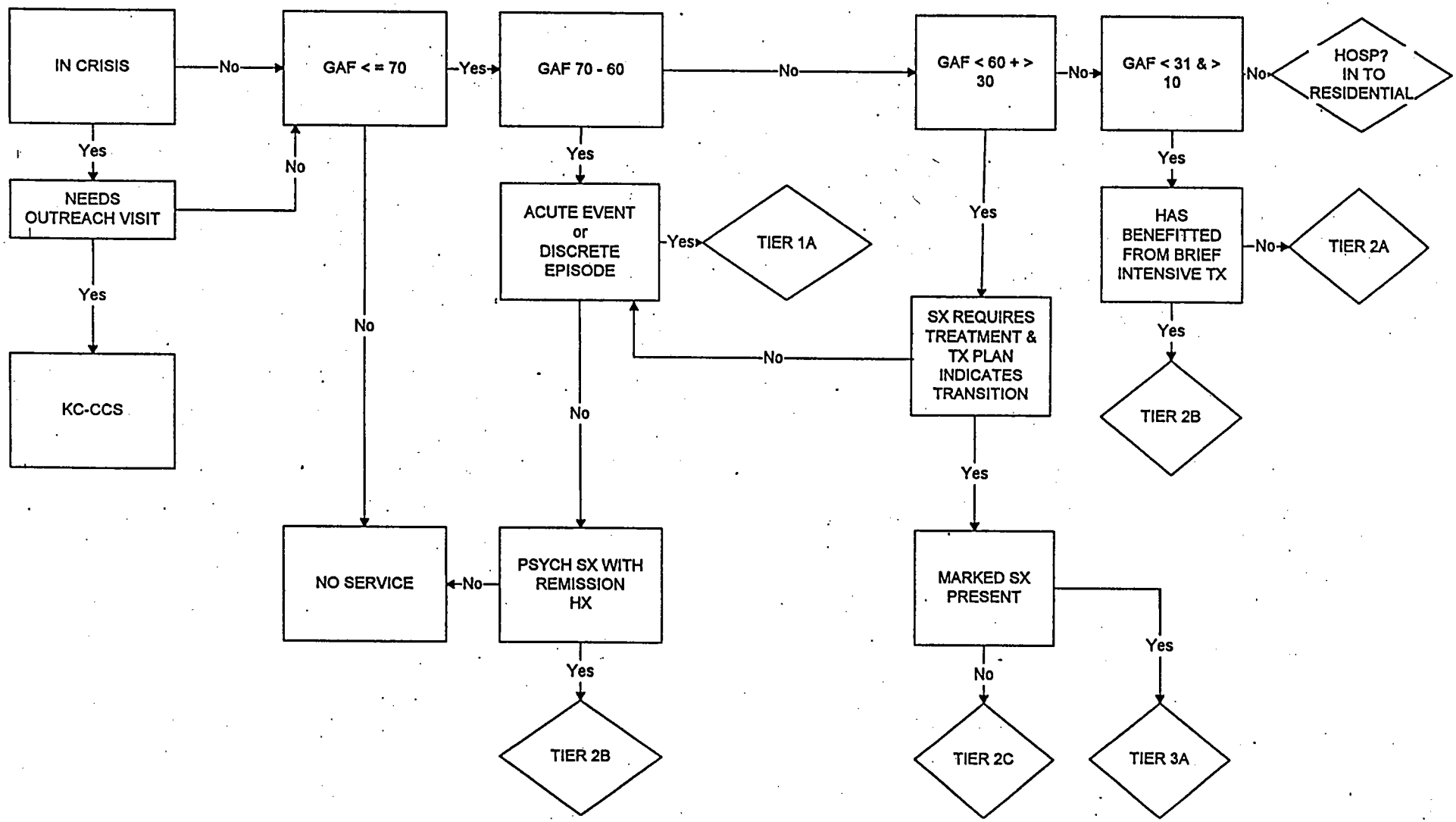
necessary, additional treatment services may be provided in this setting as part of the tier authorized benefit hours.

Intensive Residential Services: a 24 hour supervised care setting in which all board, domiciliary, and treatment services are provided and included in the Tier rate.


DSM IV DIAGNOSIS*
Yes
CGAS <=70** OR three major behaviors***
Yes
TIER 1A
No
No
NO SERVICE
Yes
CGAS <60 AND ADEQUATE PREMORBID FUNCTIONING
Yes
ADEQUATE FAMILY OR SYSTEM SUPPORTS
Yes
ACUTE CRISIS OR EXACERBATION
Yes
SERIOUS RISK ISSUES IN ONE SYSTEM
Yes
TIER 2A
Yes
NEEDS EXTENDED ON-GOING SERVICES
No
TIER 1B
Yes
DURATION ACCORDING TO AGE
Yes
TWO OF THE FOLLOWING: CIRCUMSTANCES CONDITIONS PREVIOUS SERVICES CGAS <50
No
SEE 1A
Yes
TIER 2B
Yes
NEEDS FURTHER SERVICE
No
SEE NO SERVICE
Yes
CGAS <50
Yes
DURATION BASED ON AGE AND AMENABLE TO CHANGE
No
Yes
TWO OF FOLLOWING: CONDITION CIRCUMSTANCE PREVIOUS INTENSIVE SERVICES
No
SEE 2A
Yes
TIER 2C
Yes
CGAS <40
Yes
MEETS TIER 2 REQUIREMENTS EXCLUDING DURATION
Yes
HISTORY AND OR RISK OF PLACEMENT AND POOR FUNCTIONING
No
Yes
ONE OF THE FOLLOWING: PSYCH HOSP. MULTIPLE PLACEMENTS UNDER 6 SERIOUS ATYPICAL BEHAVIOR OR SERIOUS DEVELOPMENTAL ISSUES
No
Yes
TIER 3B
Yes
MEETS ALL TIER 3A REQUIREMENTS
Yes
NEEDS CANNOT BE MET AT OTHER LEVELS OF CARE
No
TIER 3A
*Symptoms may be complicated but not caused by alcohol/ substance abuse
**CGAS need not be used for children under the age of 6
***Behavior rating scale is number 8 on the EPSDT assessment
DRAFT

DRAFT

Medical Necessity Flow Chart 1a. An individual who is new to the system



MEDICAL NECESSITY CHILDREN'S TIER LEVEL FLOW CHART

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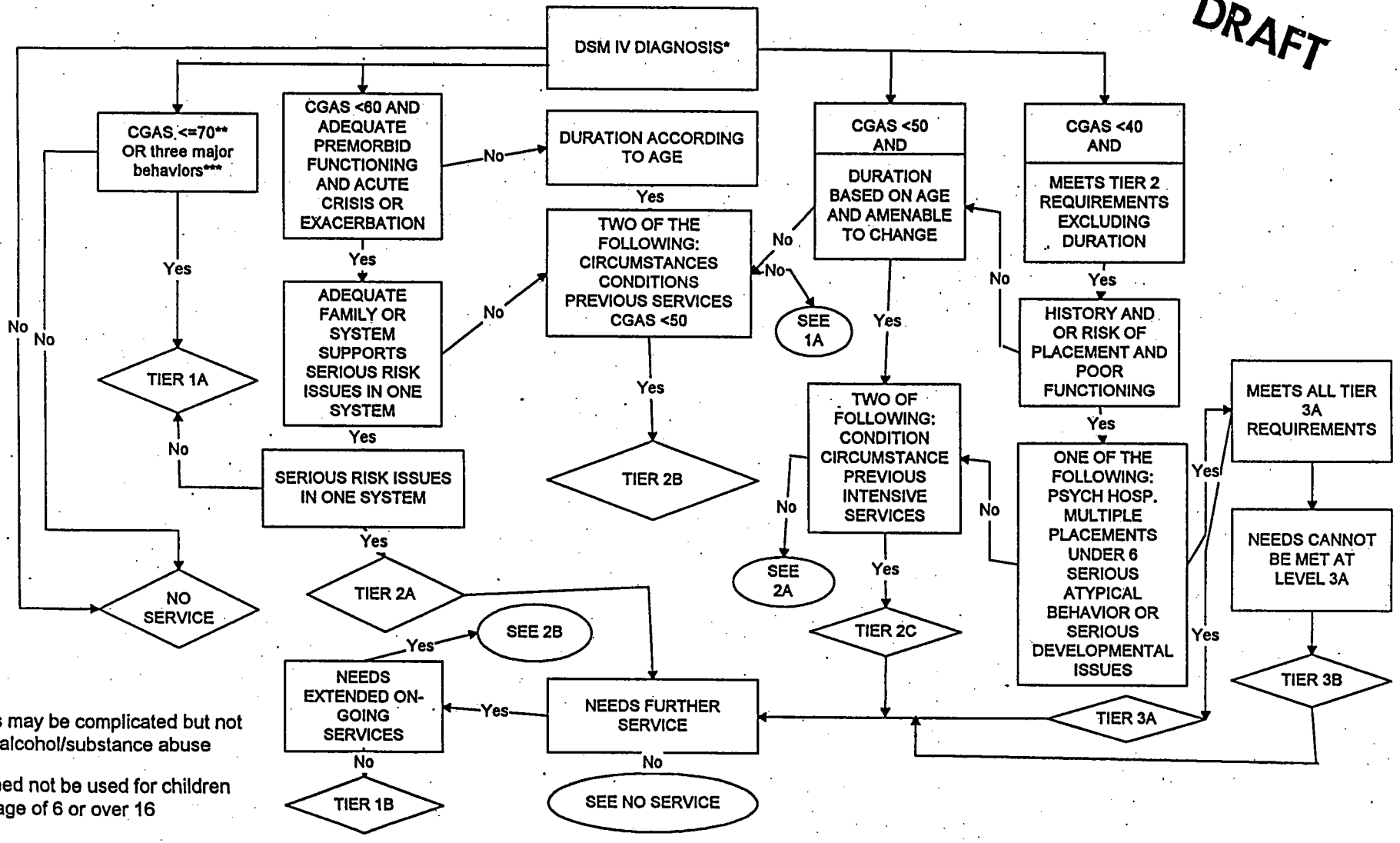
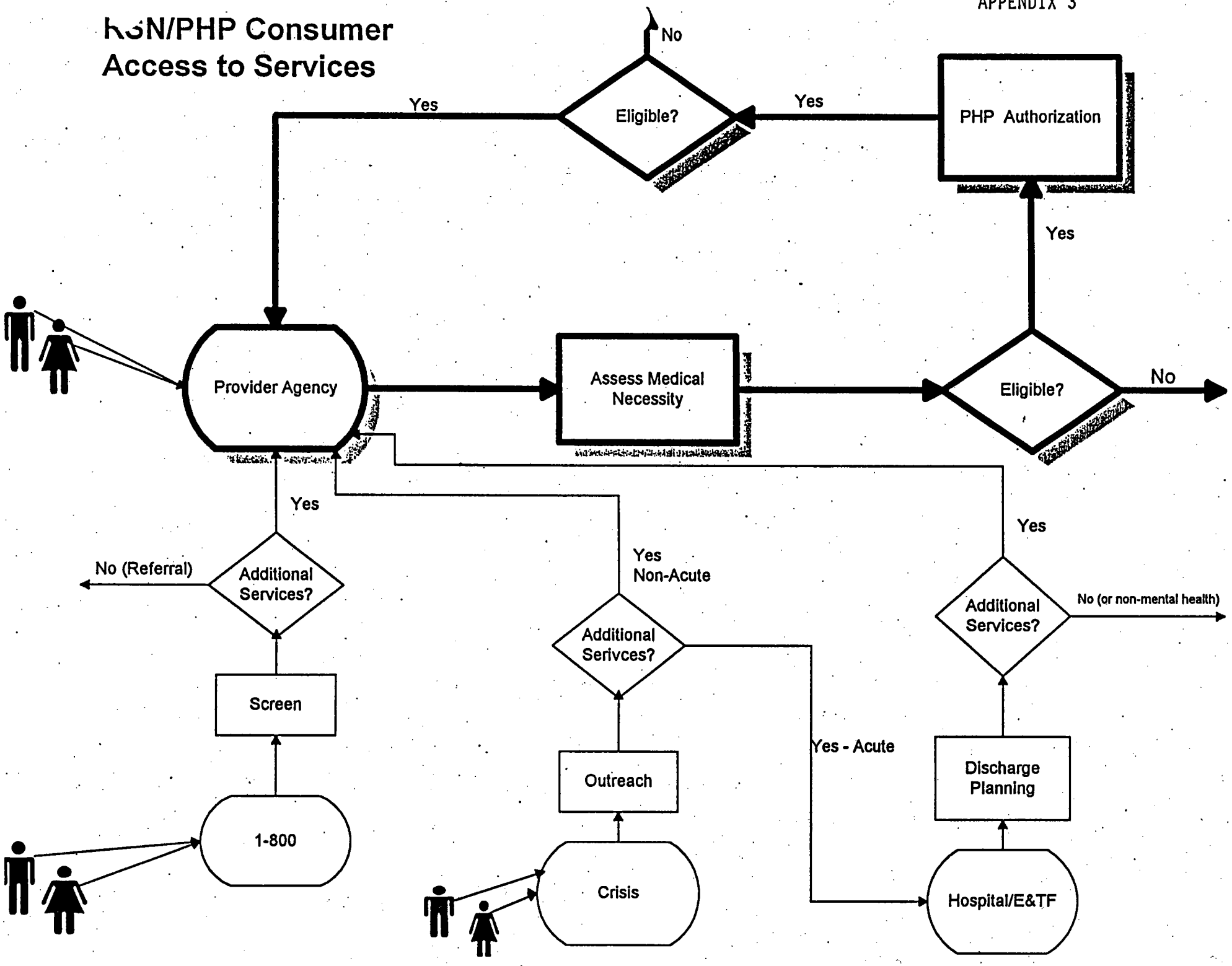


*Symptoms may be complicated but not caused by alcohol/substance abuse

**CGAS need not be used for children under the age of 6 or over 16

***Behavior rati- -cale is question number 8 on the EPSDT assessment form

K3N/PHP Consumer Access to Services



KING COUNTY REGIONAL SUPPORT NETWORK
PREPAID HEALTH PLAN
VISION AND VALUES

VISION: In partnership with our community, KCRSN will carefully define the limits of our system and, within those limits, provide the highest quality mental health services and supports to those in need. Quality will be defined by clinical standards, expected outcomes, and individual satisfaction.

VALUES:

KING COUNTY REGIONAL SUPPORT NETWORK SHALL:

1. ESTABLISH A CULTURE OF SERVICE DELIVERY AND SUPPORT TO SERVICE DELIVERY THAT IS COMMITTED TO QUALITY.

2. RESPECT THE DIVERSITY OF CULTURES, NEEDS, EXPERIENCES, GOALS OF PERSONS WITH MENTAL ILLNESS OR SERIOUS EMOTIONAL DISTURBANCES WHEN DEVELOPING STANDARDS, DESIGNING TREATMENT PLANS, AND PROVIDING SERVICES.

3. ASSURE EQUITABLE ACCESS TO SERVICES BASED ON LEVEL OF NEED AND STRIVE TO REDUCE OR ELIMINATE BARRIERS TO ACCESS.

4 INVOLVE PERSONS WHO ARE SERVED, AS WELL AS PARENTS AND SIGNIFICANT OTHERS, AS PARTNERS IN THE DEVELOPMENT OF SERVICES AND SYSTEMS AND THE MONITORING OF QUALITY.

5. BUILD SERVICES AROUND INDIVIDUAL STRENGTHS AND, AS APPROPRIATE, PROVIDE SUPPORT TO THE CHILD OR ADULT, PARENTS AND/OR SIGNIFICANT OTHERS TO ACHIEVE INTENDED OUTCOMES.

6. ASSURE THAT SERVICES PROVIDED FOR EACH INDIVIDUAL ARE THOSE DEVELOPED IN INDIVIDUAL SERVICE AND TREATMENT PLANS, DELIVERED IN THE LEAST RESTRICTIVE, APPROPRIATE SETTING.

7. COORDINATE AND COLLABORATE WITH EDUCATION, OTHER HEALTH AND SOCIAL SERVICE SYSTEMS, AND THE CRIMINAL JUSTICE SYSTEM TO ASSURE THAT SERVICE PLANS EFFECTIVELY USE ALL AVAILABLE RESOURCES TO ACHIEVE INTENDED OUTCOMES.

8. MONITOR, REPORT AND EVALUATE, SERVICES, OUTCOMES, AND SATISFACTION REGULARLY AND USE THIS DATA FOR CONTINUOUS QUALITY IMPROVEMENT OF THE SYSTEM OF SERVICES.

9. BE ACCOUNTABLE TO THE PUBLIC, AS WELL AS THOSE RECEIVING CARE, THAT RESOURCES ARE CAREFULLY MANAGED TO PROVIDE THE HIGHEST QUALITY SERVICES TO A CLEARLY DEFINED POPULATION.

10. ESTABLISH A PARTNERSHIP BETWEEN PROVIDER AGENCIES AND THE RSN/PHP WHICH BALANCES INDEPENDENCE, SUPPORT, AND DIRECTION BASED ON SHARED VALUES AND AGREED-UPON INDICATORS OF QUALITY AND ACCOUNTABILITY.

11. ADVOCATE AT THE LOCAL, STATE, AND NATIONAL LEVEL TO ASSURE THAT PERSONS WITH MENTAL ILLNESS OR SERIOUS EMOTIONAL DISTURBANCES ARE RESPECTED AS INDIVIDUALS CITIZENS AND OFFERED EQUIVALENT OPPORTUNITIES AND APPROPRIATE SUPPORT TO LEAD PRODUCTIVE AND SATISFYING LIVES.

CHANGES IN
A NEW DIRECTION, and *FOUNDATIONS FOR THE FUTURE*

For 1995, *A New Direction* will be amended as follows:

RSN/PHP role:

- Manage Medicaid dollars directly through a risk based managed care contract with the State.
- Replace eligibility requirements and enrollment process with central authorization for care. Base authorization on medical necessity definitions established for each tier. Pre-authorization will be required for all individuals except those requiring brief intervention.
- Expand eligibility definitions based on a combination of diagnosis, level of functioning, and historical clinical experiences. Match service authorization to client need and willingness to participate in care. This change will increase the number of recipients served, and will change the intensity and duration of service for many clients. For some it will mean more and others less.
- Manage admissions and length of stay for Medicaid clients requiring voluntary psychiatric inpatient care.
- Expand and manage information systems to support utilization management, quality improvement, and outcome monitoring as well as to document provider performance.
- Strengthen the client and family voices in the system design and refinement through independent satisfaction surveys; ombuds service; and review of access, quality, and outcomes by the Board-designated Quality Council which has at least 51% client and family membership.
- Directly contract with licensed community mental health centers for tier services under the PHP model, cultural interpretation and consultation through an add-on to the tier structure, and specialized crisis services through the current structure.
- Contract for a new region wide language interpretation bank to support the crisis system, and a centralized 1-800 authorization number.
- Provide direct service initial crisis outreach and investigation for involuntary treatment.

Lead agencies role:

- Eliminate subcontracting responsibility for other community mental health centers within their geographic sub region.
- Eliminate enrollment decisions (replaced by centralized authorization based on new medical necessity criteria).
- Eliminate geographic catchment areas, but retain a geographic factor in determining agency contracts and authorizations.

All community mental health centers role:

- Eliminate the current Medicaid contract with the state and the fee-for-service reimbursement model.
- Bid on new contracts with the RSN/PHP for services to both Medicaid and non-Medicaid recipients, defined by tier and reimbursed by a case rate, with financial incentives for meeting quality indicators and outcomes.
- Eliminate enrollment decisions (in the case of specialized region wide enrolling agencies) and enrollment recommendations to lead agencies.

Minority agency roles:

- Paid for their cultural expertise within their own treatment settings, and when they provide consultation to main stream providers.

In 1995, *Foundations For the Future* will be amended as follows:

RSN/PHP roles:

- Manage Medicaid dollars directly through a risk based managed care contract with the State.
- As begun through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program in 1993, pre-authorize centrally all care except brief, short-term intervention and crisis services.
- Expand eligibility definitions based on a combination of diagnosis, level of functioning, and clinical experience. Match service authorization to client need and willingness to participate in care. This will increase the number of recipients served and change the intensity and duration of service for many clients.
- Manage admissions and length of stay for public clients requiring voluntary psychiatric inpatient care.
- Expand and manage information systems to support utilization management, quality improvement, and outcome monitoring, as well as documenting provider performance.
- Strengthen the client and family voices in the system design and refinement through independent satisfaction surveys; ombuds service; review of access, quality, and outcomes by the Board-designated Quality Council which has at least 51% client and family membership.
- Directly contract with licensed community mental health centers for tier services under the PHP model, cultural interpretation and consultation through an add-on to the tier structure, and specialized crisis services through the current structure.
- Contract for a new region wide language interpretation bank to support the crisis system, and a centralized 1-800 number.
- Provide a new 24-hour crisis response and stabilization service for children.

Lead/coordinating agency roles:

- The lead agency concept was adjusted during 1991 implementation to a narrower coordinating agency role which focuses primarily on Interagency Staffing Teams and flex fund distribution. This approach is continued under the PHP proposal.
- No role in subcontracting or geographic resource management is expected.

Role of contracted children's providers within the RSN provider network:

- Eliminate the current Medicaid contract with the state and the fee-for-service reimbursement model also currently in use.
- Bid on new contracts with the RSN/PHP for services to both Medicaid and non-Medicaid recipients, defined by tier and reimbursed by a case rate with financial incentives for meeting quality indicators and outcomes.

Minority agency roles:

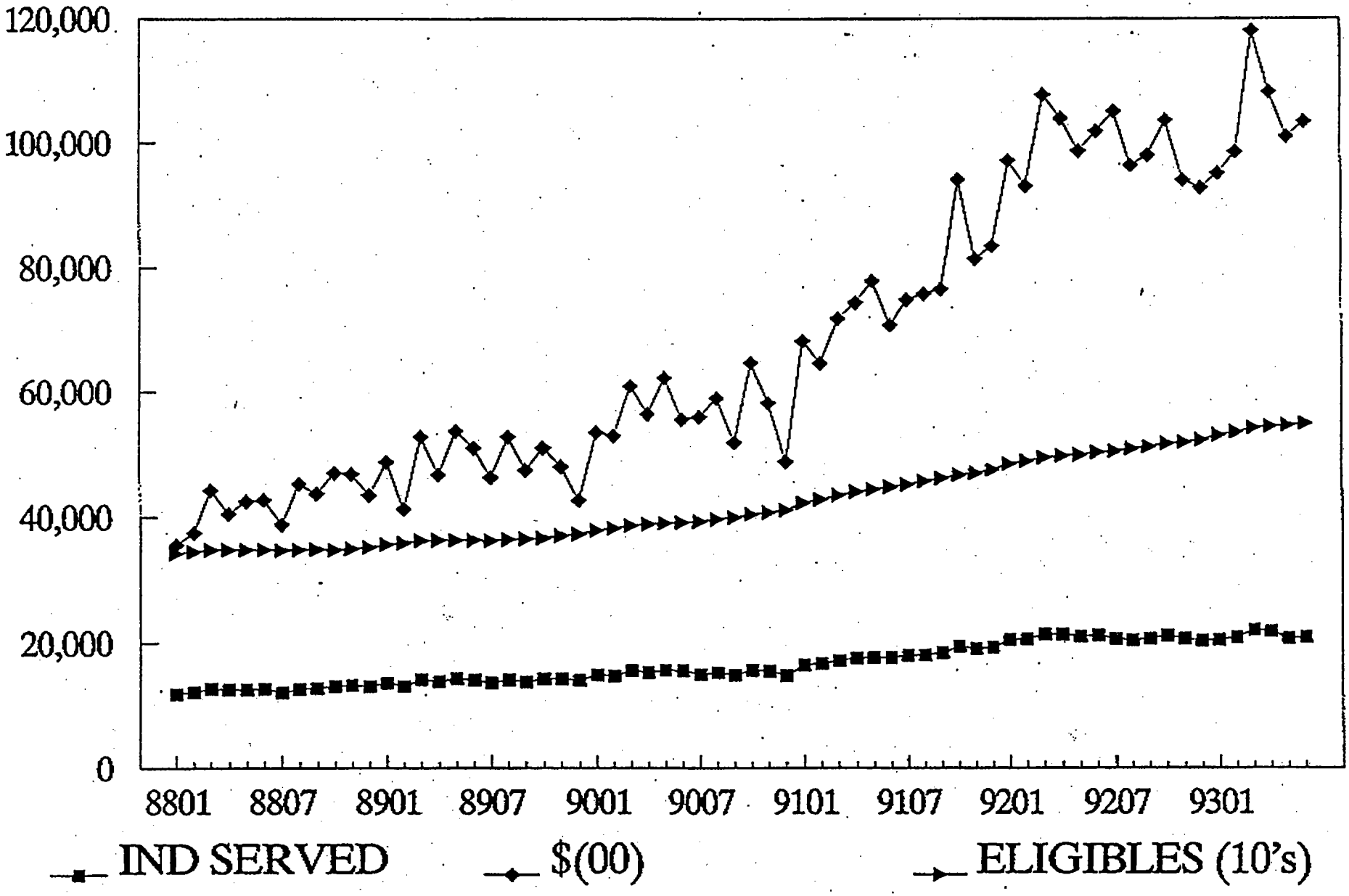
- As in the adult system, minority agencies will be paid for their cultural expertise within their own treatment settings and when they provide consultation to main stream providers.

Crisis response

- The current mobile crisis response team for the RSN serves only adults and youth over age 13. The RSN/PHP will contract for a new region wide team to provide crisis response and short-term stabilization for families with children in crisis. The team will link children to necessary ongoing mental health and/or child welfare or other system services.

MENTAL HEALTH TITLE XIX HISTORY

STATEWIDE



MENTAL HEALTH TITLE XIX HISTORY

KING COUNTY

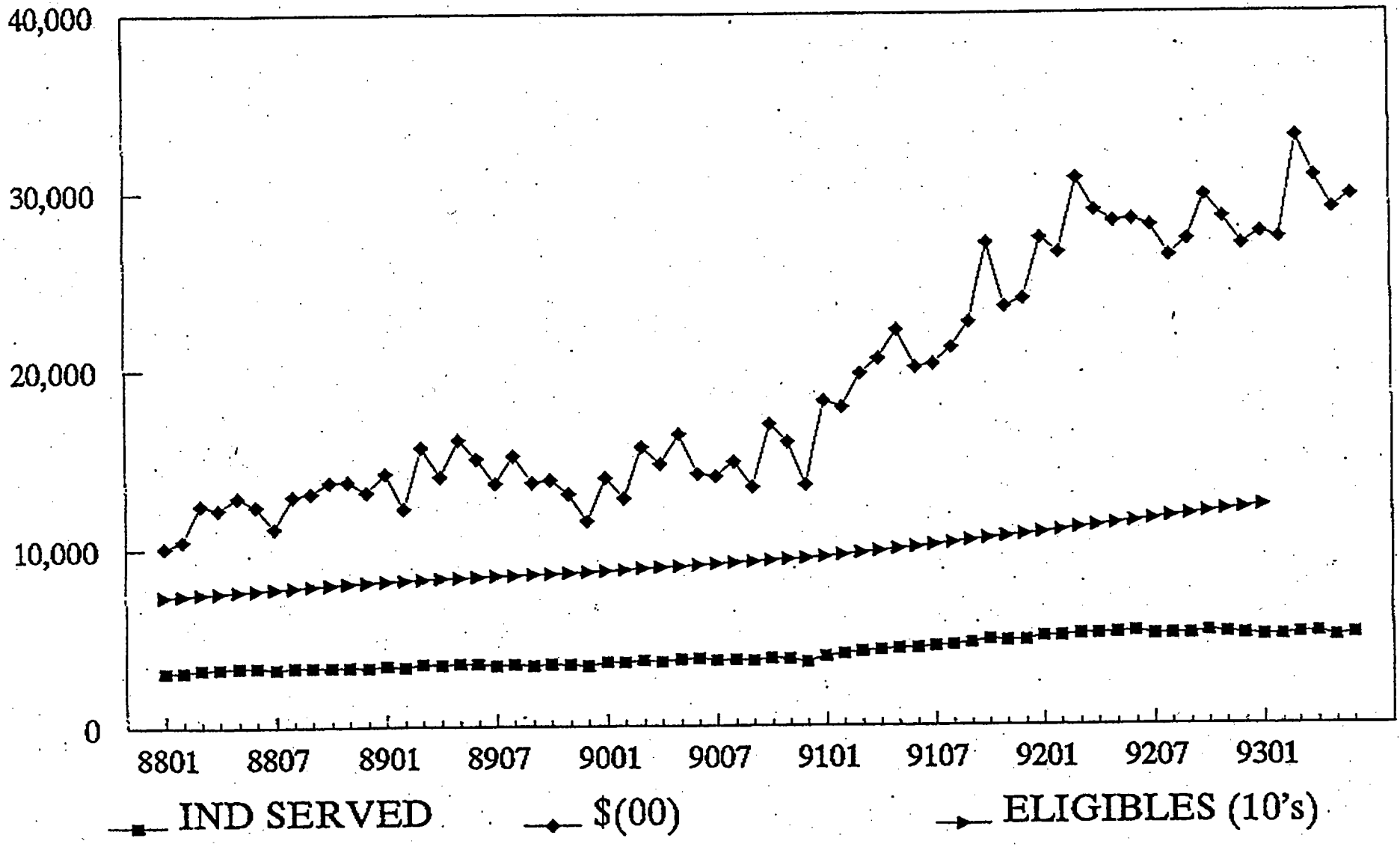
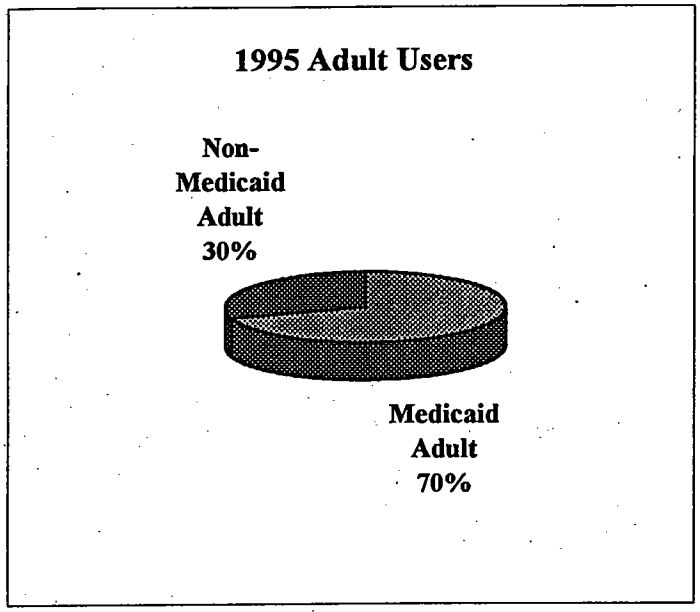
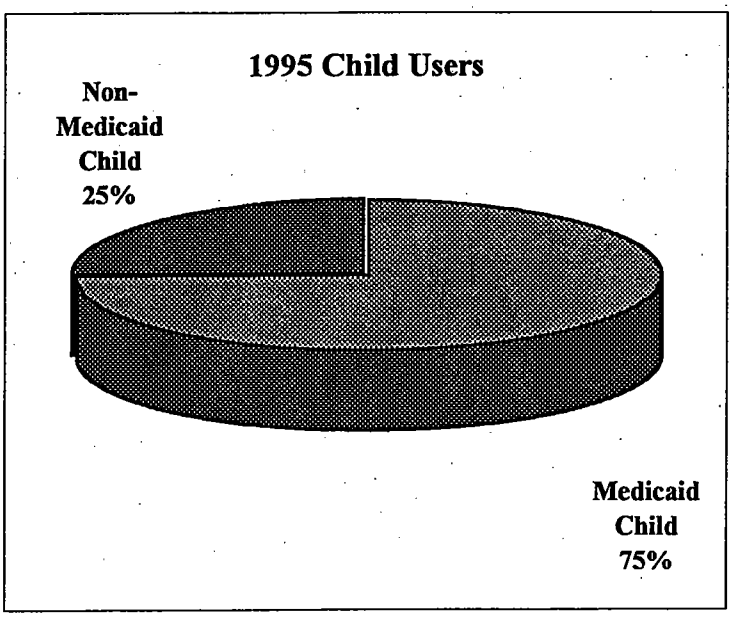


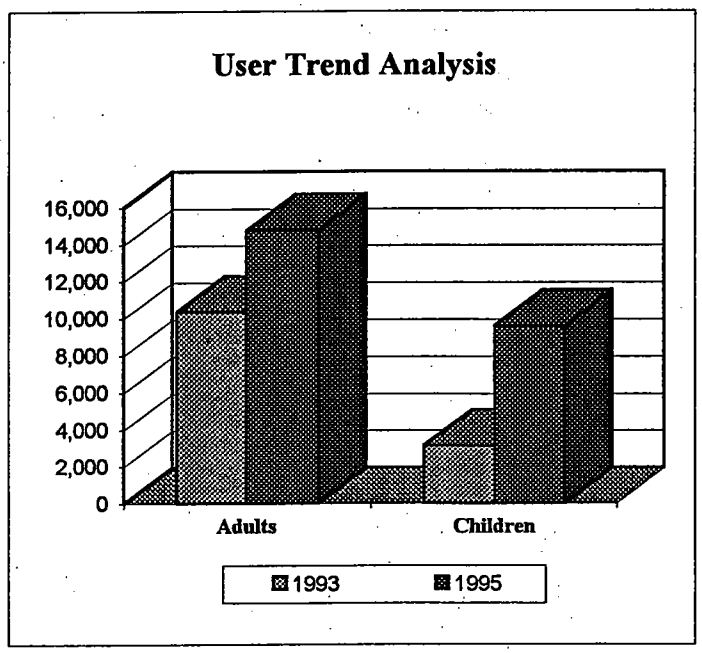
Table 1 KCPHP Summary Report

1995 Medium $ Scenario

	Medicaid		Non-Medicaid		Other	Total
	Adult	Child	Adult	Child		
Section 1: Statistics						
Annual Eligibles	91,971	115,249	n/a	n/a	n/a	n/a
Annual Users	10,347	7,203	4,420	2,388	n/a	24,357
Penetration Rate	11.25%	6.25%	n/a	n/a	n/a	n/a







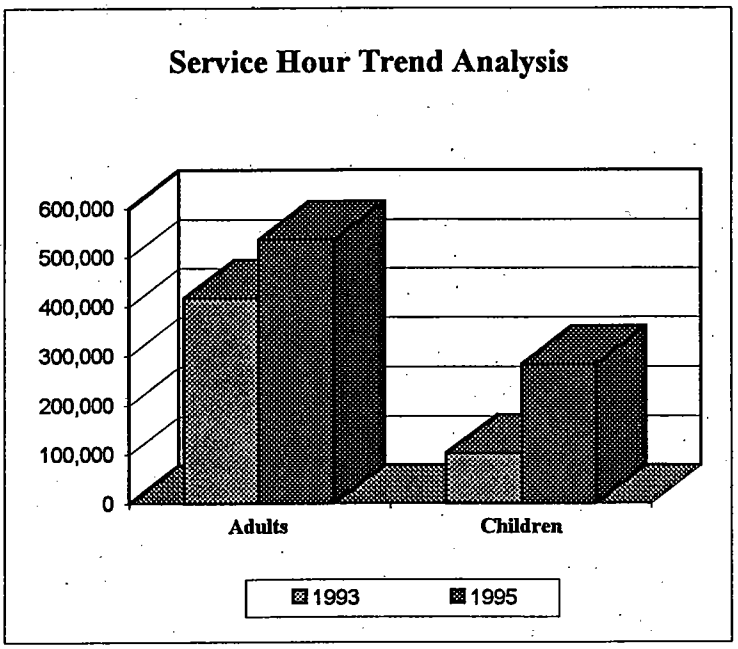


Table 1 KCPHP Summary Report

1995 Medium $ Scenario

Comparison of 1993 and 1995 Users and Average Standarized Service Hours

Adults

	1993		1995	
	Users	Average Standardized Service Hours	Users	Average Standardized Service Hours
Tier 1a Brief treatment	6,020	3.49	6,108	4.00
Tier 1b Aftercare	1,286	8.43	1,305	14.62 *
Tier 2a Maintenance	2,814	29.05	3,839	28.00
Tier 2b Brief intensive	76	23.08	105	28.00
Tier 2c Short-term rehab	932	63.23	1,374	60.00
Tier 3a Intensive long-term rehab	1,127	125.29	1,679	118.00
Tier 3b Exceptional care	335	315.97	357	260.00

Children

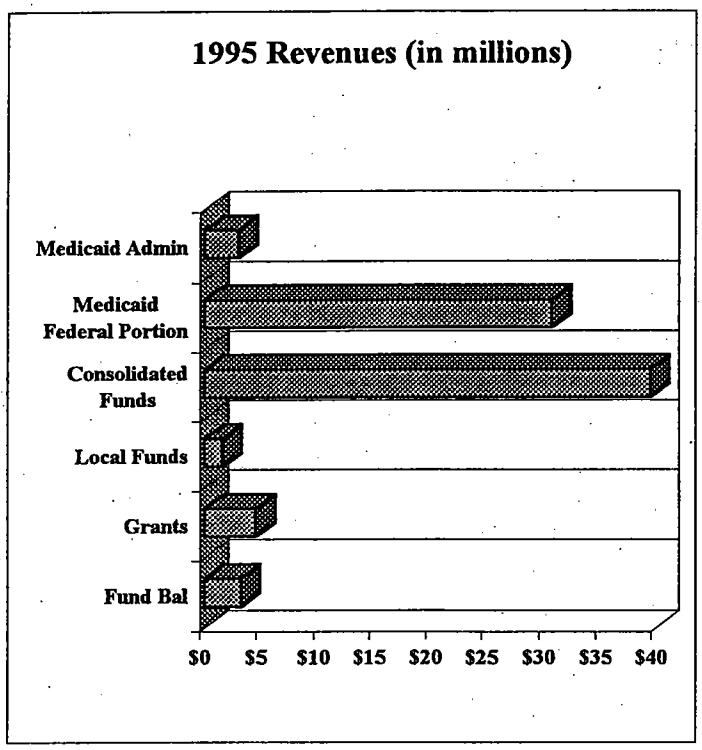
	1993		1995	
	Users	Average Service Hours	Users	Average Service Hours
Tier 1a Brief treatment	1,931	4.66	6,103	5.00
Tier 1b Aftercare	43	10.45	137	88.78 *
Tier 2a Maintenance	540	27.55	304	28.00
er 2b Brief intensive	94	27.19	1,736	28.00
ıer 2c Short-term rehab	122	63.24	383	60.00
Tier 3a Intensive long-term rehab	201	124.11	660	118.00
Tier 3b Exceptional care	123	346.32	270	298.00

*The number of average service hours in Tier 1b in 1995 will be adjusted.

Table 1 KCPHP Summary Report

1995 Medium $ Scenario

					Total	
Section 2: Revenue and Expense						
Revenue						
Carryforward Fund Balances	-	-	-	-	3,207,844	3,207,844
Grant Funding	-	-	-	-	4,512,184	4,512,184
Local Millage & Interest	-	-	-	-	1,582,599	1,582,599
Consolidated Medicaid Match	20,282,008	8,115,439	-	-	-	28,397,447
Consolidated Funds	-	-	-	-	11,145,090	11,145,090
Medicaid Federal Portion	21,945,782	8,781,165	-	-	-	30,726,948
Medicaid Administrative Funds	-	-	-	-	2,956,220	2,956,220
Total Revenue	42,227,790	16,896,605	0	0	23,403,936	82,528,331
Expense						
Case Managed OP Services	20,341,902	15,206,944	6,945,981	2,539,371	-	45,034,198
Residential Services	-	-	-	-	7,519,753	7,519,753
Evaluation & Treatment Centers	-	-	-	-	6,865,365	6,865,365
RSN Crisis & Commitment Services	-	-	-	-	3,931,573	3,931,573
Other RSN Services	-	-	-	-	8,740,327	8,740,327
County Administrative Costs	-	-	-	-	4,126,417	4,126,417
Excess Utilization Risk Pool & Reserve	-	-	-	-	5,043,675	5,043,675
Total Expense	20,341,902	15,206,944	6,945,981	2,539,371	36,227,109	81,261,306
Excess(Deficit)	21,885,888	1,689,660	(6,945,981)	(2,539,371)	(12,823,172)	1,267,025



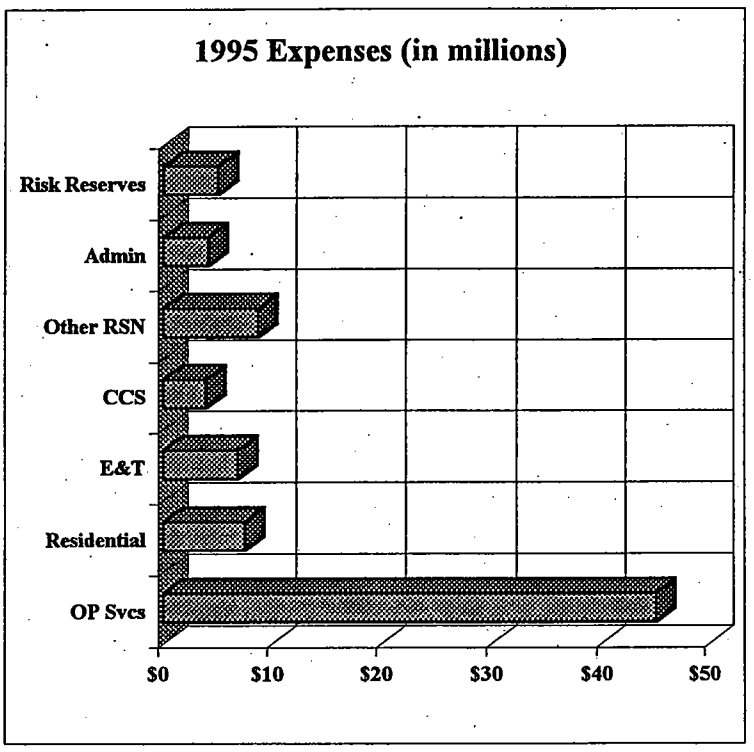


Table 2 KCPHP Statement of Revenue and Expense — 1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetratio 2H95 Penetration: 12% Adult, 7.5% Child

	Medicaid Case Mg Adult Svcs	Medicaid Case Mg Child Svcs	Non-Medicaid Case Mg Services	Overhead Services	Other RSN Activities	1995 Grand Total	Key Data	Data Label
Revenue								
RSN-Related Funds								
Fund Balance	0	0	0	0	3,207,844	3,207,844		Est fund balance end of 1994
Estimated Earned Interest	0	0	0	0	94,254	94,254		At 2.25% interest rate
Federal Block Grant	0	0	0	0	1,357,750	1,357,750		
Federal Inpatient - Medicaid	0	0	0	0	628,000	628,000		50% federal share 1H95 & 2H95
PATH	0	0	0	0	155,747	155,747		
ACCESS	0	0	0	0	1,681,684	1,681,684		
DCFS Position	0	0	0	0	31,800	31,800		
DCFS Flex	0	0	0	0	66,666	66,666		
Current Expense	0	0	0	0	399,037	399,037		
Current Expense Fund for JDP	0	0	0	0	91,500	91,500		
Millage	0	0	0	0	1,488,345	1,488,345		
City of Seattle for CDP	0	0	0	0	100,000	100,000		
Total RSN-Related Funds	0	0	0	0	9,302,626	9,302,626		
PHP-Related Funds								
Consolidated Medicaid Match	20,282,008	8,115,439	0	0	0	28,397,447	48.03%	XIX portion
Consolidated Funds	0	0	0	0	11,145,090	11,145,090	39,542,537	Total Consol $
Medicaid Federal Portion	21,945,782	8,781,165	0	0	0	30,726,948	51.97%	Federal share
Title XIX Administrative Funds	0	0	0	2,956,220	0	2,956,220	5.00%	DSHS %
Total PHP-Related Funds	42,227,790	16,896,605	0	2,956,220	11,145,090	73,225,705		
Total Revenue	42,227,790	16,896,605	0	2,956,220	20,447,717	82,528,331		
Adult Case Managed OP Services	18,720,423	0	6,945,981	0	0	25,666,404	$63.00	hourly cost
Adult Medicare Crossover Services	1,621,479	0	0	0	0	1,621,479	30.60%	Paid at 20% case rate
Child Case Managed OP Services	0	15,206,944	2,539,371	0	0	17,746,315	$63.00	hourly cost
Long-term Residential Rehab	0	0	0	0	5,853,907	5,853,907		$88/day less pt participation
Board & Domiciliary Services	0	0	0	0	1,518,400	1,518,400		$24/day less pt participation
Lead Agency Admin of Residential	0	0	0	0	147,446	147,446	2.00%	of LTR + Board & Domiciliary
Evaluation & Treatment Centers	0	0	0	0	6,865,365	6,865,365	1.026	2.6% COLA
RSN Crisis & Commitment Services	0	0	0	0	3,931,573	3,931,573	1.026	2.6% COLA for Crisis Clinic
Geriatric Crisis Assessment	0	0	0	0	332,525	332,525	1.026	2.6% COLA
Children's Regional Crisis Team	0	0	0	0	205,200	205,200	1.026	2.6% COLA
Hospital Diversion	0	0	0	0	229,510	229,510	1.026	2.6% COLA
Voluntary Hospital Diversion	0	0	0	0	628,000	628,000		For 1995
Crisis Respite Services	0	0	0	0	161,258	161,258	1.026	2.6% COLA
Lead Agency Hospital Liaisons	0	0	0	0	175,020	175,020		HWS, EMH, NWMH, CPC
Categorical Programs	0	0	0	0	2,185,897	2,185,897		ACCESS, PATH, DCFS, CDP
DVR	0	0	0	0	172,904	172,904		DVR for all of 1995
DAETN	0	0	0	0	17,955	17,955		2.6% COLA
Interagency Staffing Team	0	0	0	0	153,900	153,900	1.026	2.6% COLA
Parent Advocacy	0	0	0	0	25,650	25,650	1.026	2.6% COLA
Consumer Projects	0	0	0	0	25,650	25,650	1.026	2.6% COLA
Provider Training	0	0	0	0	200,000	200,000		
Flex Funds	0	0	0	0	307,800	307,800	1.026	2.6% COLA
Language Interpretation	0	0	0	0	300,000	300,000		
Cultural Interpretation Add-On	0	0	0	0	1,097,369	1,097,369		
Cultural Interp Add-On: LTR	0	0	0	0	21,688	21,688		For 240 served in LTR
Contingency Fund*	0	0	0	0	2,500,000	2,500,000		Contingency for RSN programs
County Administrative Costs	0	0	0	4,126,417	0	4,126,417	5.00%	Capped at 5% of total revenue
Excess Utilization Risk Pool**	0	0	0	2,736,012	0	2,736,012	5.00%	
Risk Reserve	0	0	0	2,307,663	0	2,307,663	5.00%	Of case managed services
Total Expense	20,341,902	15,206,944	9,485,352	9,170,091	27,057,017	81,261,306		
Excess(Deficit)	21,885,888	1,689,660	-9,485,352	-6,213,871	-6,609,301	1,267,025		

*To support adjustments in the case rate and other specialized services outside of the PHP structure.

**5% of case managed services + $300k WSH risk pool + $128k Native American exemption

Table 3 Medicaid Summary Data Estimates — 1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration — **2H95 Penetration: 12% Adult, 7.5% Child**

	Adults CY 1995	Children CY 1995	Total CY 1995	Table
Medicaid Summary Data				
Annual Eligibles	91,971	115,249	207,220	4
Annual Users	10,347	7,203	17,550	4
Annual Penetration Rate	11.25%	6.25%	8.47%	4
Average Monthly Eligibles	72,825	78,715	151,540	4
Average Monthly Users	6,975	2,709	9,685	4
Average Monthly Penetration Rate	9.58%	3.44%	6.39%	4
Tier 1a Users	3,874	4,318	8,192	5
Tier 1b Users	827	97	925	5
Tier 2a Users	2,836	245	3,081	5
Tier 2b Users	78	1,397	1,475	5
Tier 2c Users	1,015	308	1,323	5
Tier 3a Users	1,416	595	2,011	5
Tier 3b Users	301	243	544	5
	10,347	7,203	17,550	5
Tier 1a Service Hours	19,369	21,589	40,958	5
Tier 1b Service Hours	16,680	11,988	28,668	5
Tier 2a Service Hours	79,412	6,846	86,258	5
Tier 2b Service Hours	2,182	39,120	41,302	5
Tier 2c Service Hours	62,917	19,097	82,013	5
Tier 3a Service Hours	167,084	70,238	237,321	5
Tier 3b Service Hours	78,196	72,503	150,699	5
	425,838	241,380	667,218	5
Cost per Service Hour	$63.00	$70.00	$70.00	
Total Cost	$26,827,817	$16,896,605	$46,705,290	
Tier 1 PMPM Payment Rate	$2.11	$0.71	n/a	6
Tier 2 PMPM Payment Rate	$369.64	$556.16	n/a	6
Tier 3 PMPM Payment Rate	$1,329.41	$1,974.49	n/a	6
Medicaid Tier Billings	$43,721,368	$23,079,642	$66,801,009	4
Children's Fee For Service Billings	n/a	$16,896,605	n/a	4
Upper Payment Limit	$42,227,790	$12,855,244	$55,083,034	4
Realizable Revenue	$42,227,790	$16,896,605	$59,124,395	4
Administrative Revenue @ 5% of UPL	$2,111,390	$844,830	$2,956,220	

Table 3 Non-Medicaid Summary Data Estimates

	Adults CY 1995	Children CY 1995	Total CY 1995	Table
Non-Medicaid Summary Data				
Tier 1a Users	2,234	1,785	4,019	5
Tier 1b Users	477	40	517	5
Tier 2a Users	1,003	59	1,062	5
Tier 2b Users	28	338	366	5
Tier 2c Users	359	75	433	5
Tier 3a Users	263	64	328	5
Tier 3b Users	56	26	82	5
	4,420	2,388	6,808	5
Tier 1a Service Hours	11,169	8,925	20,095	5
Tier 1b Service Hours	2,386	201	2,586	5
Tier 2a Service Hours	28,083	1,658	29,741	5
Tier 2b Service Hours	772	9,476	10,248	5
Tier 2c Service Hours	22,250	4,626	26,876	5
Tier 3a Service Hours	31,059	7,588	38,647	5
Tier 3b Service Hours	14,536	7,833	22,368	5
	110,254	40,307	150,561	5

Table 4 Medicaid Statistics — 1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration — **2H95 Penetration: 12% Adult, 7.5% Child**

A. ANNUAL STATISTICS

Period	Data Type	Eligibles	Users	Penetration Rate	Eligible % Change	User % Change	Note
Adults							
FY 1992	Actual	75,580	7,149	9.46%	n/a	n/a	(a)
CY 1992	Actual	75,768	7,492	9.89%	0.25%	4.80%	
CY 1993	Actual/Est	79,512	7,951	10.00%	4.94%	6.13%	(b)
CY 1994	**Estimated**	**84,315**	**8,853**	**10.50%**	**6.04%**	**11.34%**	**(b)**
1H95	**Estimated**	**45,986**	**4,828**	**10.50%**	**-45.46%**	**-45.46%**	
2H95	**Estimated**	**45,986**	**5,518**	**12.00%**	**-45.46%**	**-37.67%**	**(b)**
Children							
FY 1992	Actual	74,113	1,810	2.44%	n/a	n/a	(a)
CY 1992	Actual	81,366	1,899	2.33%	9.79%	4.92%	
CY 1993	Actual/Est	83,784	**2,120**	**2.53%**	2.97%	**11.62%**	**(b)**
CY 1994	**Estimated**	**90,445**	**4,070**	**4.50%**	**7.95%**	**92.01%**	**(b) (c)**
1H95	**Estimated**	**57,625**	**2,881**	**5.00%**	**-36.29%**	**-29.21%**	
2H95	**Estimated**	**57,625**	**4,322**	**7.50%**	**-36.29%**	**6.19%**	**(b) (c)**

B. AVERAGE MONTHLY STATISTICS

Period	Data Type	Eligibles	Users	Penetration Rate	Eligible % Change	User % Change	Note
Adults							
FY 1992	Actual	54,452	4,461	8.19%	n/a	n/a	(a)
CY 1992	Actual	58,415	4,723	8.09%	7.28%	5.87%	
CY 1993	Actual/Est	62,958	**5,150**	**8.18%**	7.78%	**9.04%**	**(b)**
CY 1994	**Estimated**	***66,760***	**5,443**	**8.15%**	**6.04%**	**5.69%**	**(b) (d)**
CY 1995	**Estimated**	***72,825***	**6,975**	**9.58%**	**9.08%**	**28.15%**	**(b) (d)**
Children							
FY 1992	Actual	53,395	851	1.59%	n/a	n/a	(a)
CY 1992	Actual	58,621	945	1.61%	9.79%	11.05%	
CY 1993	Actual/Est	65,783	**1,150**	**1.75%**	12.22%	**21.69%**	**(b)**
CY 1994	**Estimated**	***71,015***	**1,172**	**1.65%**	**7.95%**	**1.89%**	**(b)(c)(d)**
CY 1995	**Estimated**	***78,715***	**2,709**	**3.44%**	**10.84%**	**131.23%**	**(b)(c)(d)**

Notes:

(a) = FY = 7/1 - 6/30

(b) = Items in bold print are KCRSN estimates

(c) = Children's penetration rate is expected to increase due to EPSDT increase

(d) = Items in bold italics print are Washington State DSHS estimates

Comments:

1,494 Increase in users between 94 and 95

299 Tiers 2 & 3 = 20% of 1995 increase

103 New Medicare crossovers in 95=34.6% of T2 & T3

3,063 Medicare crossovers in 1994 (@ 34.6%)

3,167 Medicare crossover total in 1995

30.60% % of Medicare in caseload in 1995

Table 5a Medicaid Service Volumes - Medicaid Adults

1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration

Penetration = 12% adults, 8.7% children

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Common Data				T-19 Data											
Tier	Funding Source	Annual Stndrd Hours	Median Std Hrs	1993 RSN T-19-Only Ratio	1993 T-19 Ratio	# of 93 T-19 Users	New T-19 Users Ratio	# of New T-19 Users	# of 95 T-19 Users	# of Tier Service Hours	After-care Hours	Total Service Hours	Mos of Service Avg	Mos of Service # of Svc Months	Avg Mo Users
1a brief treatment	Medicaid only	<15	5.00	11.51%	27.34%	2,174	35.33%	846	3,020	15,100		15,100	4.49	13,559	1,130
	Medicare x-over		5.00	3.25%	7.73%	615	9.99%	239	854	4,269		4,269	5.67	4,841	403
	Subtotal		5.00	14.77%	35.07%	2,788	45.32%	1,086	3,874	19,369	0	19,369	4.75	18,401	1,533
1b aftercare	Medicaid only	<15	5.00	2.46%	5.84%	464	7.55%	181	645	3,225	8,685	11,910	4.49	2,896	241
	Medicare x-over		5.00	0.70%	1.65%	131	2.13%	51	182	912	3,858	4,770	5.67	1,034	86
	Subtotal		5.00	3.15%	7.49%	596	9.68%	232	827	4,137	12,543	16,680	4.75	3,930	328
2a maintenance	Medicaid only	>=15 & <50	28.00	8.57%	20.36%	1,619	23.01%	551	2,170	60,767		60,767	10.15	22,028	1,836
	Medicare x-over		28.00	2.63%	6.25%	497	7.06%	169	666	18,644		18,644	10.63	7,078	590
	Subtotal		28.00	11.21%	26.61%	2,116	30.07%	720	2,836	79,412	0	79,412	10.26	29,106	2,426
2b brief intensive	Medicaid only	>=15 & <50	28.00	0.23%	0.54%	43	0.71%	17	60	1,669		1,669	10.15	605	50
	Medicare x-over		28.00	0.07%	0.16%	13	0.22%	5	18	512		512	10.63	194	16
	Subtotal		28.00	0.29%	0.70%	56	0.93%	22	78	2,182	0	2,182	10.26	800	67
2c short term rehab	Medicaid only	>=50 & <80	62.00	3.37%	8.00%	636	3.55%	85	721	44,732		44,732	11.20	8,081	673
	Medicare x-over		62.00	1.37%	3.25%	259	1.45%	35	293	18,185		18,185	11.56	3,391	283
	Subtotal		62.00	4.74%	11.26%	895	5.00%	120	1,015	62,917	0	62,917	11.30	11,471	956
3a intensive L.T. rehab	Medicaid only	>=80 & <200	118.00	4.42%	10.50%	835	5.06%	121	956	112,793		112,793	11.56	11,050	921
	Medicare x-over		118.00	2.13%	5.05%	402	2.44%	58	460	54,291		54,291	11.69	5,378	448
	Subtotal		118.00	6.55%	15.55%	1,236	7.50%	180	1,416	167,084	0	167,084	11.60	16,428	1,369
3b exceptional care	Medicaid only	>=200	260.00	0.90%	2.14%	170	0.96%	23	193	50,179		50,179	11.83	2,283	190
	Medicare x-over		260.00	0.50%	1.19%	95	0.54%	13	108	28,017		28,017	11.92	1,284	107
	Subtotal		260.00	1.40%	3.33%	265	1.50%	36	301	78,196	0	78,196	11.86	3,568	297
	Medicaid only			31.46%	74.71%	5,940	76.18%	1,825	7,765	288,465	8,685	297,150			5,042
	Medicare x-over			10.65%	25.29%	2,011	23.82%	571	2,582	124,830	3,858	128,689			1,933
	Total			42.11%	100.00%	7,951	100.00%	2,396	10,347	413,295	12,543	425,838			6,975

Explanation of columns	inputs for calculating column 6	used to split T-19 users	Total # is from Table 2	estimate of new users	calc from Col 8	Columns 7 + 9	Column 4 times Column 10	10hrs/yr for 2b, 2c & 3a	Tier hrs + After-care hrs	1993 T-19 data	Columns 10 x 14	Col 15 divided by 12 mos

- All Tier median standard hours based on 1993 historical data except for:
  - Tier 3b reduced by 25%. Tier 3a increased by the persons reduced from Tier 3b.
  - New T19 users adjusted to fall more heavily into Tier 1.

Table 5b Medicaid Service Volumes - Non-Medicaid Adults 1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration **Penetration = 12% adults, 8.7% children**

1	2	3	4	17	18	19	20	21	22
Common Data				**Non-T19 Data**					
		Annual		Non-	Non-T19		Mos of Service		Avg
Tier	Funding Source	Stndrd Hours	Median Std Hrs	T19 %	Users	Svc Hrs	Avg	# of Svc Months	Mo Users
1a	Medicaid only		5.00				4.49		0
brief	Medicare x-over	<15	5.00				5.67		0
treatment	Subtotal		5.00	37%	2,234	11,169	4.75	10,611	884
1b	Medicaid only		5.00				4.49	13,004	1,084
aftercare	Medicare x-over	<15	5.00				5.67	5,863	489
	Subtotal		5.00	37%	477	2,386	4.75	2,266	189
2a	Medicaid only	>=15	28.00				10.15		
maintenance	Medicare x-over	& <50	28.00				10.63		
	Subtotal		28.00	26%	1,003	28,083	10.26	10,293	858
2b	Medicaid only	>=15	28.00				10.15		
brief	Medicare x-over	& <50	28.00				10.63		
intensive	Subtotal		28.00	26%	28	772	10.26	283	24
2c	Medicaid only	>=50	62.00				11.20		
short term	Medicare x-over	& <80	62.00				11.56		
rehab	Subtotal		62.00	26%	359	22,250	11.30	4,057	338
3a	Medicaid only	>=80	118.00				11.56		
intensive	Medicare x-over	& <200	118.00				11.69		
L.T. rehab	Subtotal		118.00	16%	263	31,059	11.60	3,054	254
3b	Medicaid only		260.00				11.83		
exceptional	Medicare x-over	>=200	260.00				11.92		
care	Subtotal		260.00	16%	56	14,536	11.86	663	55
	Medicaid only								
Total	Medicare x-over								
	Total				4,420	110,254			2,390

Explanation of columns	RSN estimates	Calc of Columns 10 & 17	Column 4 times Column 18	assume same as T-19	Column 18 times Column 20	Col 21 divided by 12 mos

- % Non-T19 in caseload: 29.93%
- Non-T19 set at 37% in Tier 1, 26% in Tier 2, and 16% in Tier 3 for adults, for overall rate of 30%.

Table 5c Medicaid Service Volumes - Medicaid Children

1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration

Penetration = 12% adults, 8.7% children

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Common Data				**T-19 Data**											
Tier	**Funding Source**	**Annual Stndrd Hours**	**Median Std Hrs**	**1993 RSN T-19-Only Ratio**	**1993 T-19 Ratio**	**# of 93 T-19 Users**	**New T-19 Users Ratio**	**# of New T-19 Users**	**# of 95 T-19 Users**	**# of Tier Service Hours**	**After-care Hours**	**Total Service Hours**	**Mos of Service Avg**	**Mos of Service # of Svc Months**	**Avg Mo Users**
1a brief treatment	Medicaid only	<15	**5.00**	**35.68%**	57.53%	1,931	57.53%	2,387	4,318	21,589		21,589	**2.49**	10,751	896
	Medicare x-over		**5.00**	**0.00%**	0.00%	0	0.00%	0	0	0		0	**0.00**	0	0
	Subtotal		**5.00**	35.68%	57.53%	1,931	57.53%	2,387	4,318	21,589	0	21,589	2.49	10,751	896
1b aftercare	Medicaid only	<15	**5.00**	**0.80%**	1.29%	43	1.29%	54	97	486	11,502	11,988	**2.49**	242	20
	Medicare x-over		**5.00**	**0.00%**	0.00%	0	0.00%	0	0	0	0	0	**0.00**	0	0
	Subtotal		**5.00**	0.80%	1.29%	43	1.29%	54	97	486	11,502	11,988	2.49	242	20
2a maintenance	Medicaid only	>=15 & <50	**28.00**	**2.23%**	3.60%	95	3.60%	149	245	6,846		6,846	**7.12**	1,741	145
	Medicare x-over		**28.00**	**0.00%**	0.00%	0	0.00%	0	0	0		0	**0.00**	0	0
	Subtotal		**28.00**	2.23%	3.60%	95	3.60%	149	245	6,846	0	6,846	7.12	1,741	145
2b brief intensive	Medicaid only	>=15 & <50	**28.00**	**12.83%**	20.69%	539	20.69%	858	1,397	39,120		39,120	**7.12**	9,948	829
	Medicare x-over		**28.00**	**0.00%**	0.00%	0	0.00%	0	0	0		0	**0.00**	0	0
	Subtotal		**28.00**	12.83%	20.69%	539	20.69%	858	1,397	39,120	0	39,120	7.12	9,948	829
2c short term rehab	Medicaid only	>=50 & <80	**62.00**	**2.78%**	4.48%	122	4.48%	186	308	19,097		19,097	**8.02**	2,470	206
	Medicare x-over		**62.00**	**0.00%**	0.00%	0	0.00%	0	0	0		0	**0.00**	0	0
	Subtotal		**62.00**	2.78%	4.48%	122	4.48%	186	308	19,097	0	19,097	8.02	2,470	206
3a intensive L.T. rehab	Medicaid only	>=80 & <200	**118.00**	**5.43%**	8.76%	232	8.76%	363	595	70,238		70,238	**7.94**	4,726	394
	Medicare x-over		**118.00**	**0.00%**	0.00%	0	0.00%	0	0	0		0	**0.00**	0	0
	Subtotal		**118.00**	5.43%	8.76%	232	8.76%	363	595	70,238	0	70,238	7.94	4,726	394
3b exceptional care	Medicaid only	>=200	**298.00**	**2.26%**	3.64%	92	3.64%	151	243	72,503		72,503	**10.83**	2,635	220
	Medicare x-over		**298.00**	**0.00%**	0.00%	0	0.00%	0	0	0		0	**0.00**	0	0
	Subtotal		**298.00**	2.26%	3.64%	92	3.64%	151	243	72,503	0	72,503	10.83	2,635	220
Total	Medicaid only			62.01%	100.00%	3,054	100.00%	4,149	7,203	229,878	11,502	241,380			2,709
	Medicare x-over			0.00%	0.00%	0	0.00%	0	0	0	0	0			0
	Total			62.01%	100.00%	3,054	100.00%	4,149	7,203	229,878	11,502	241,380			2,709

Explanation of columns	inputs for calculating column 6	used to split T-19 users	Total # is from Table 2	estimate of new users	calc from Col 8	Columns 7 + 9	Column 4 times Column 10	10hrs/yr for 2b, 2c & 3a	Tier hrs + After-care hrs	1993 T-19 data	Columns 10 x 14	Col 15 divided by 12 mos

- All Tier median standard hours based on 1993 historical data except for:
  - Tier 1 median increased from historical value of 4 to 5 standard hours.
  - Tier 2a and 2b increased to adult historical median level.
  - Tier 3b reduced by 25%. Tier 3a increased by the persons removed from Tier 3b.

Table 5d Medicaid Service Volumes - Non-Medicaid Children 1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration **Penetration = 12% adults, 8.7% children**

1	2	3	4	17	18	19	20	21	22
Common Data				**Non-T19 Data**					
					Non-T19		**Mos of Service**		**Avg**
Tier	**Funding Source**	**Annual Stndrd Hours**	**Median Std Hrs**	**Non-T19 %**	**Users**	**Svc Hrs**	**Avg**	**# of Svc Months**	**Mo Users**
1a	Medicaid only		**5.00**				**2.49**		
brief	Medicare x-over	<15	**5.00**				**0.00**		
treatment	Subtotal		**5.00**	29.25%	1,785	8,925	2.49	4,445	370
1b	Medicaid only		**5.00**				**2.49**		
aftercare	Medicare x-over	<15	**5.00**				**0.00**		
	Subtotal		**5.00**	29.25%	40	201	2.49	100	8
2a	Medicaid only	>=15	**28.00**				**7.12**		
maintenance	Medicare x-over	& <50	**28.00**				**0.00**		
	Subtotal		**28.00**	19.50%	59	1,658	7.12	422	35
2b	Medicaid only	>=15	**28.00**				**7.12**		
brief	Medicare x-over	& <50	**28.00**				**0.00**		
intensive	Subtotal		**28.00**	19.50%	338	9,476	7.12	2,410	201
2c	Medicaid only	>=50	**62.00**				**8.02**		
short term	Medicare x-over	& <80	**62.00**				**0.00**		
rehab	Subtotal		**62.00**	19.50%	75	4,626	8.02	598	50
3a	Medicaid only	>=80	**118.00**				**7.94**		
intensive	Medicare x-over	& <200	**118.00**				**0.00**		
L.T. rehab	Subtotal		**118.00**	9.75%	64	7,588	7.94	511	43
3b	Medicaid only		**298.00**				**10.83**		
exceptional	Medicare x-over	>=200	**298.00**				**0.00**		
care	Subtotal		**298.00**	9.75%	26	7,833	10.83	285	24
	Medicaid only								
Total	Medicare x-over								
	Total				2,388	40,307			522

Explanation of columns	RSN estimates	Calc of Columns 10 & 17	Column 4 times Column 18	assume same as T-19	Column 18 times Column 20	Col 21 divided by 12 mos

- % Non-T19 in caseload: 24.90%
- Non-T19 set at 29% in Tier 1, 20% in Tier 2, and 10% in Tier 3 for children, for overall rate of 25%.

Table 6 Estimated Medicaid Annual Revenue — 1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration — **2H95 Penetration: 12% Adult, 7.5% Child**

Tier	PMPM Payment Rate	Average Monthly Eligibles	Annual Users	Average Monthly Users	Revenue Calculation	Federal Share 51.97%	PHP Match 48.03%
Adults - 1995, 12% Penetration Rate 2H95							
Tiers 1a & b	$2.11	72,825	17,245	1,861	$1,843,929		
Tier 2a & b	$369.64	n/a	2,836	2,492	$11,054,434		
Tier 2c	$369.64	n/a	1,015	956	$4,240,197		
Tier 3a	$1,329.41	n/a	1,416	1,369	$21,840,000		
Tier 3b	$1,329.41	n/a	301	297	$4,742,808		
Total			22,812	6,975	$43,721,368		
Upper Payment Limit					$42,227,790		
Allowable Revenue					$42,227,790	$21,945,782	$20,282,008
Children - 1995, 7.5% Penetration Rate 2H95							
Tiers 1a & b	$0.71	78,715	15,917	916	$670,652		
Tier 2a & b	$556.16	n/a	245	974	$6,500,735		
Tier 2c	$556.16	n/a	308	206	$1,373,843		
Tier 3a	$1,974.49	n/a	595	394	$9,331,787		
Tier 3b	$1,974.49	n/a	243	220	$5,202,626		
Total			17,308	2,709	$23,079,642		
Fee for Svc Hrs					241,380		
Average Rate					$70.00		
FFS Billings					$16,896,605		
Upper Payment Limit					$12,855,244		
					$16,896,605	$8,781,165	$8,115,439
Total			40,120	9,685	$59,124,395	$30,726,948	$28,397,447
Upper Payment Limit					$55,083,034	$28,626,653	$26,456,381
over(under) UPL					$4,041,361	$2,100,295	$1,941,066

Table 7 Cultural Interpretation Add-On

1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration

2H95 Penetration: 12% Adult, 7.5% Child

Tier	Ethnic Group	Distribution in Population	1995 Est Distribution	1995 Users	N	Add-On Standardized Weight	Rate	Total
ADULTS								
1a	African-American/Other Black	11.30%	11.13%	6,108	679	2	$63	$85,614
	Asian/Pacific Islander	6.90%	6.53%	6,108	399	2	$63	$50,253
	Caucasian	71.30%	64.85%	6,108	3,961	0	$63	$0
	Native American	5.60%	5.23%	6,108	319	2	$63	$40,241
	Hispanic Culture		2.20%	6,108	135	2	$63	$16,954
	Deaf/Hearing Impaired	2.10%	2.10%	6,108	128	2	$63	$16,161
	Sexual Minority		7.00%	6,108	428	2	$63	$53,870
	Other Cultural Minority*		0.90%	6,108	55	2	$63	$6,926
	Other/Unknown**	2.80%	0.06%	6,108	4	2	$63	$462
	Subtotal 1a	100.00%	100.00%		6,107			$270,479
1b	African-American/Other Black	11.30%	11.13%	1,305	145	2	$63	$18,287
	Asian/Pacific Islander	6.90%	6.53%	1,305	85	2	$63	$10,734
	Caucasian	71.30%	64.85%	1,305	846	0	$63	$0
	Native American	5.60%	5.23%	1,305	68	2	$63	$8,595
	Hispanic Culture		2.20%	1,305	29	2	$63	
	Deaf/Hearing Impaired	2.10%	2.10%	1,305	27	2	$63	
	Sexual Minority		7.00%	1,305	91	2	$63	
	Other Cultural Minority*		0.90%	1,305	12	2	$63	
	Other/Unknown**	2.80%	0.06%	1,305	1	2	$63	$99
	Subtotal 1b	100.00%	100.00%		1,305			$37,714
2a	African-American/Other Black	10.80%	11.13%	3,839	427	4	$63	$107,629
	Asian/Pacific Islander	7.10%	6.53%	3,839	251	4	$63	$63,174
	Caucasian	73.40%	64.85%	3,839	2,490	0	$63	$0
	Native American	3.10%	5.23%	3,839	201	4	$63	$50,588
	Hispanic Culture		2.20%	3,839	85	4	$63	
	Deaf/Hearing Impaired	2.10%	2.10%	3,839	81	4	$63	
	Sexual Minority		7.00%	3,839	269	4	$63	
	Other Cultural Minority*		0.90%	3,839	35	4	$63	
	Other/Unknown**	3.50%	0.06%	3,839	2	4	$63	$580
	Subtotal 2a	100.00%	100.00%		3,839			$221,972
2b	African-American/Other Black	10.80%	11.13%	105	12	1	$63	$739
	Asian/Pacific Islander	7.10%	6.53%	105	7	1	$63	$434
	Caucasian	73.40%	64.85%	105	68	0	$63	$0
	Native American	3.10%	5.23%	105	6	1	$63	$347
	Hispanic Culture		2.20%	105	2	1	$63	
	Deaf/Hearing Impaired	2.10%	2.10%	105	2	1	$63	
	Sexual Minority		7.00%	105	7	1	$63	
	Other Cultural Minority*		0.90%	105	1	1	$63	
	Other/Unknown**	3.50%	0.06%	105	0	1	$63	$4
	Subtotal 2b	100.00%	100.00%		105			$1,525

*Includes Caucasian (Non-Hispanic) refugees.

**Includes persons who were not reported as any defined racial group or whose racial status was unknown.

Table 7 Cultural Interpretation Add-On

1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration

2H95 Penetration: 12% Adult, 7.5% Child

Tier	Ethnic Group	Distribution in Population	1995 Est Distribution	1995 Users	N	Add-On Standardized Weight	Rate	Total
2c	African-American/Other Black	11.90%	11.13%	1,374	153	2	$63	$19,255
	Asian/Pacific Islander	3.30%	6.53%	1,374	90	2	$63	$11,302
	Caucasian	77.30%	64.85%	1,374	891	0	$63	$0
	Native American	2.30%	5.23%	1,374	72	2	$63	$9,050
	Hispanic Culture		2.20%	1,374	30	2	$63	
	Deaf/Hearing Impaired	2.10%	2.10%	1,374	29	2	$63	
	Sexual Minority		7.00%	1,374	96	2	$63	
	Other Cultural Minority*		0.90%	1,374	12	2	$63	
	Other/Unknown**	3.10%	0.06%	1,374	1	2	$63	$104
	Subtotal 2c	100.00%	100.00%		1,374			$39,711
3a	African-American/Other Black	11.40%	11.13%	1,679	187	3	$63	$35,307
	Asian/Pacific Islander	3.10%	6.53%	1,679	110	3	$63	$20,724
	Caucasian	79.00%	64.85%	1,679	1,089	0	$63	$0
	Native American	2.50%	5.23%	1,679	88	3	$63	$16,595
	Hispanic Culture		2.20%	1,679	37	3	$63	
	Deaf/Hearing Impaired	2.10%	2.10%	1,679	35	3	$63	
	Sexual Minority		7.00%	1,679	118	3	$63	
	Other Cultural Minority*		0.90%	1,679	15	3	$63	
	Other/Unknown**	1.90%	0.06%	1,679	1	3	$63	$190
	Subtotal 3a	100.00%	100.00%		1,679			$72,816
3b	African-American/Other Black	8.10%	11.13%	357	40	4	$63	$9,999
	Asian/Pacific Islander	5.10%	6.53%	357	23	4	$63	$5,869
	Caucasian	81.80%	64.85%	357	231	0	$63	$0
	Native American	2.40%	5.23%	357	19	4	$63	$4,700
	Hispanic Culture		2.20%	357	8	4	$63	
	Deaf/Hearing Impaired	2.10%	2.10%	357	7	4	$63	
	Sexual Minority		7.00%	357	25	4	$63	
	Other Cultural Minority*		0.90%	357	3	4	$63	
	Other/Unknown**	0.50%	0.06%	357	0	4	$63	$54
	Subtotal 3b	100.00%	100.00%		357			$20,622
	Total Adults			14,766				$664,838

*Includes Caucasian (Non-Hispanic) refugees.

**Includes persons who were not reported as any defined racial group or whose racial status was unknown.

Table 7 Cultural Interpretation Add-On

1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration

2H95 Penetration: 12% Adult, 7.5% Child

Tier	Ethnic Group	Distribution in Population	1995 Est Distribution	1995 Users	N	Add-On Standardized Weight	Rate	Total
CHILDREN								
1a	African-American/Other Black	16.90%	16.82%	6,103	1,026	2	$63	$129,307
	Asian/Pacific Islander	6.60%	9.39%	6,103	573	2	$63	$72,174
	Caucasian	58.70%	54.68%	6,103	3,337	0	$63	$0
	Native American	9.30%	9.21%	6,103	562	2	$63	$70,805
	Hispanic Culture		4.17%	6,103	254	2	$63	
	Deaf/Hearing Impaired	1.40%	1.40%	6,103	85	2	$63	
	Sexual Minority		4.00%	6,103	244	2	$63	
	Other Cultural Minority*		0.09%	6,103	5	2	$63	
	Other/Unknown**	7.10%	0.25%	6,103	15	2	$63	$1,922
	Subtotal 1a	100.00%	100.00%		6,103			$274,209
1b	African-American/Other Black	16.90%	16.82%	137	23	2	$63	$2,909
	Asian/Pacific Islander	6.60%	9.39%	137	13	2	$63	$1,624
	Caucasian	58.70%	54.68%	137	75	0	$63	$0
	Native American	9.30%	9.21%	137	13	2	$63	$1,593
	Hispanic Culture		4.17%	137	6	2	$63	
	Deaf/Hearing Impaired	1.40%	1.40%	137	2	2	$63	
	Sexual Minority		4.00%	137	5	2	$63	
	Other Cultural Minority*		0.09%	137	0	2	$63	
	Other/Unknown**	7.10%	0.25%	137	0	2	$63	$43
	Subtotal 1b	100.00%	100.00%		137			$6,168
2a	African-American/Other Black	20.30%	16.82%	304	51	4	$63	$12,871
	Asian/Pacific Islander	7.70%	9.39%	304	29	4	$63	$7,184
	Caucasian	60.10%	54.68%	304	166	0	$63	$0
	Native American	5.40%	9.21%	304	28	4	$63	$7,048
	Hispanic Culture		4.17%	304	13	4	$63	
	Deaf/Hearing Impaired	1.40%	1.40%	304	4	4	$63	
	Sexual Minority		4.00%	304	12	4	$63	
	Other Cultural Minority*		0.09%	304	0	4	$63	
	Other/Unknown**	5.10%	0.25%	304	1	4	$63	$191
	Subtotal 2a	100.00%	100.00%		304			$27,294
2b	African-American/Other Black	20.30%	16.82%	1,736	292	1	$63	$18,387
	Asian/Pacific Islander	7.70%	9.39%	1,736	163	1	$63	$10,263
	Caucasian	60.10%	54.68%	1,736	949	0	$63	$0
	Native American	5.40%	9.21%	1,736	160	1	$63	$10,068
	Hispanic Culture		4.17%	1,736	72	1	$63	
	Deaf/Hearing Impaired	1.40%	1.40%	1,736	24	1	$63	
	Sexual Minority		4.00%	1,736	69	1	$63	
	Other Cultural Minority*		0.09%	1,736	2	1	$63	
	Other/Unknown**	5.10%	0.25%	1,736	4	1	$63	$273
	Subtotal 2b	100.00%	100.00%		1,736			$38,992

*Includes Caucasian (Non-Hispanic) refugees.

**Includes persons who were not reported as any defined racial group or whose racial status was unknown.

Table 7 Cultural Interpretation Add-On

1995 Medium $ Scenario

SCENARIO: Children @ 5% 1H95 penetration

2H95 Penetration: 12% Adult, 7.5% Child

Tier	Ethnic Group	Distribution in Population	1995 Est Distribution	1995 Users	N	Add-On Standardized Weight	Rate	Total
2c	African-American/Other Black	20.50%	16.82%	383	64	2	$63	$8,107
	Asian/Pacific Islander	6.60%	9.39%	383	36	2	$63	$4,525
	Caucasian	65.00%	54.68%	383	209	0	$63	$0
	Native American	3.30%	9.21%	383	35	2	$63	$4,439
	Hispanic Culture		4.17%	383	16	2	$63	
	Deaf/Hearing Impaired	1.40%	1.40%	383	5	2	$63	
	Sexual Minority		4.00%	383	15	2	$63	
	Other Cultural Minority*		0.09%	383	0	2	$63	
	Other/Unknown**	3.20%	0.25%	383	1	2	$63	$121
	Subtotal 2c	100.00%	100.00%		383			$17,192
3a	African-American/Other Black	23.40%	16.82%	660	111	3	$63	$20,962
	Asian/Pacific Islander	3.00%	9.39%	660	62	3	$63	$11,700
	Caucasian	63.30%	54.68%	660	361	0	$63	$0
	Native American	3.00%	9.21%	660	61	3	$63	$11,478
	Hispanic Culture		4.17%	660	27	3	$63	
	Deaf/Hearing Impaired	1.40%	1.40%	660	9	3	$63	
	Sexual Minority		4.00%	660	26	3	$63	
	Other Cultural Minority*		0.09%	660	1	3	$63	
	Other/Unknown**	5.90%	0.25%	660	2	3	$63	$312
	Subtotal 3a	100.00%	100.00%		660			$44,451
3b	African-American/Other Black	35.00%	16.82%	270	45	4	$63	$11,424
	Asian/Pacific Islander	0.80%	9.39%	270	25	4	$63	$6,376
	Caucasian	54.70%	54.68%	270	147	0	$63	$0
	Native American	3.30%	9.21%	270	25	4	$63	$6,255
	Hispanic Culture		4.17%	270	11	4	$63	
	Deaf/Hearing Impaired	1.40%	1.40%	270	4	4	$63	
	Sexual Minority		4.00%	270	11	4	$63	
	Other Cultural Minority*		0.09%	270	0	4	$63	
	Other/Unknown	4.80%	0.25%	270	1	4	$63	$170
	Subtotal 3b	100.00%	100.00%		270			$24,226
	Total Children			9,591				$432,531

*Includes Caucasian (Non-Hispanic) refugees.

**Includes persons who were not reported as any defined racial group or whose racial status was unknown.

KING COUNTY RSN/PHP
draft 3/28/94

Case Rates

Assumptions regarding RSN/PHP overall approach:

- The RSN/PHP will contract for services to both T. XIX and non-T. XIX consumers using the same approach--authorization for a level of care, reimbursed by a case rate.

- Providers of care will be certified as providers separate from the contract process. Being certified will make a provider eligible for a contract.

- The RSN/PHP is interested in certifying providers with an active quality improvement program.

Assumptions regarding quality/utilization and payment:

- There will be clinical quality indicators and utilization management/outcome measures that are tracked at the provider level, where improvement plans will be developed as trend data suggests the necessity.

- Providers who do not show continuous improvement towards performance on the indicators/measures will not be recertified as providers.

- Payment methodologies will not be used to manage or direct the aggregate quality and utilization management changes that are needed.

- Payment methodologies will include methods of recoupment if the minimum number of service hours at the service level authorized for an individual are not provided.

Assumptions regarding contracting:

- Not all providers will be contracted for all Tiers.

- Provider contracts will be for a quarterly projected minimum base of expected T1/2/3 authorizations and an expected proportion of non-T-XIX consumers--not all resources will be committed in initial contracts; resources will be added to provider contracts as specific authorizations occur beyond the base (contracts will be written and managed differently).

- Case rates will be paid prospectively for all individuals that are authorized for a level of care at the beginning of the month--payment will be made on or before the fifteenth working day of the month.

- Billings to DSHS at the beginning of every month will be based upon the same listing of individuals and the level of care authorized.

- Provider reconciliations will be necessary on a monthly basis to deal with added/expired authorizations, retrospective eligibility, and periodic recoupment for rates paid that did not match to level of care provided. A year end reconciliation would be used for moves between agencies and other changes.

Assumptions regarding case rates:

- Case rates will be established for each level of care and paid out monthly (T2 and T3) or quarterly (T1) for each individual authorized to a level of care. (See case rate model attachment.)

- Case rates will be based on the median number of standardized service hours and the standardized cost per hour, which acknowledges that some individuals will use more and others will use less service, within the level of care.

- Case rates for medicare cross over consumers will be paid at 20% of the established rate. Similar methodologies will be developed for other third party payors.

Implications for authorization:

- Authorization means that a level of care has been established for an individual, that the provider is ready to serve the individual at that level of care, and the PHP is prepared to make a case rate payment for the individual's level of care.

- All individuals will need to be authorized to a level of care and a primary care provider (within an agency provider).

- All individuals will be required to receive services within the provider authorized to provide care unless a request is made to change primary care provider/agency provider or unless the authorized provider is purchasing services from another provider.

- Individuals could be authorized to a T1 level of care through a process that delegates assessment and screening to the provider and retroactive authorization by the PHP--agencies would have a minimum base of T1 case rates; however, at some point in the year, it may be necessary to preauthorize at the PHP if the number of requests for T1 service requires the development of waiting lists--wait list management is the responsibility of the PHP in a case rated system.

- All T2 and T3 individuals will be preauthorized for care.

- An individual who reappears for care in the course of the year, unless authorized to a higher level of care, will be provided with hours remaining in the case rate originally paid to the provider.

- An individual who reappears for care in the course of the year, having utilized the maximum hours within the level of care originally authorized (and it is still the appropriate, medically necessary level of care), will be provided additional services as an exception to policy.

- All individuals authorized to a T2 or T3 time limited level of care will be eligible for additional authorization to T1b services, if medically necessary. (See case rate model attachment.)

Implications for MIS:

- A benefit tracking system will be required to track authorization to a level of care, expiration date of the authorization and actual utilization of standardized hours.

- This system should be updated for authorizations daily, for utilization no less than weekly.

Sample of tracking for each authorization:

authorization start date	authorization end date
2/3/94	8/3/94

maximum benefit hours	hours provided to date	maximum remaining hours
80	32	38

- This system should be accessible by all authorized providers.

- This system should be able to report every month on all authorizations that have expired where the individual has received less than the minimum hours for the level of care authorized. (See case rate model attachment.)

- The attached samples of monthly reports demonstrate the approach.

CASE RATES (model for case rating using 1993 high rounded medians and $63/hour.)
draft 5/13/1994

UNIFORM BENEFIT service level	standardized annual hr. limits	time frame	adult median hrs	adult total case rate	adult payment case rate	payment cycle*	child median hrs	child total case rate	child payment case rate	minimum service for case rate
1a: brief treatment	<15	up to 6 mo	5	$315	$157.50	quarterly	5	$315	$157.50	1 hr/6 mo
1b: aftercare	<15	annual			$78.75	quarterly			$78.75	1 hr/yr
2a: maintenance	>15-50	annual	28	$1,764	$147.00	monthly	28	$1,764	$147.00	15 hrs/yr
2b: brief intensive	>15-50**	up to 3 mo			$588.00	monthly			$588.00	15 hrs/3 mo
inpatient	30 days									
PHP										
2c: short term rehabilitation	>50-80**	up to 6 mo	62	$3,906	$651.00	monthly	62	$3,906	$651.00	50 hrs/6 mo
3a: intensive/long trm rehab	>80-200**	up to 12 mo	118	$7,434	$619.50	monthly	118	$7,434	$619.50	7 hrs/mo/12 mo
3b: exceptional care	>200	up to 12 mo	260	$16,380	$1,365.00	monthly	298	$18,774	$1,564.50	individually established
residential	n/a	annual								
extended inpatient	n/a									

*individuals who are medicare/medicaid will have coverage for 20% of the case rate
*recoupment for T1: at the expiration date of the authorization, if the minimum number of hours are not delivered, the entire rate is recouped
*recoupment for T2: at the expiration date of the authorization, if the minimum number of hours are not delivered, the difference between the T1 and T2 rate is recouped
*recoupment for T3: if the minimum monthly hours are not delivered, the monthly rate is recouped

**individuals authorized to these levels of care will be eligible for 1b authorization for aftercare (1b may also be the only level of care required for other individuals)

Agency A
Adults

unique identifier	authorization start date	end date	authorized level of care	medicare x over	non t. XIX	other third party
1	2/11/95	8/31/95	1a	n	n	n
2	1/26/95	12/31/95	1b	n	n	n
3	2/28/95	12/31/95	2a	y	n	n
4	3/1/95	6/1/95	2b	n	y	n
5	3/12/95	9/12/95	2c	n	n	n
6	3/24/95	12/24/95	3a	y	n	n
7	3/3/95	12/31/95	3b	n	n	y

Adults Summary:	prior T1	medicare @ 20%	non medicare @ rate	rate	total paid
1a	1			$157.50	$0
1b	1			$78.75	$0
2a		1		$147.00	$29
2b			1	$588.00	$588
2c			1	$651.00	$651
3a		1		$619.50	$124
3b			1	$1,564.50	$1564
					$2957

Child
as above

Agency B
as above

All Agencies

Adults Summary:	prior T1	medicare @ 20%	non medicare @ rate	rate	total paid

(the summary reformatted becomes DSHS billing)

DRAFT

1995-1997 FINANCIAL PLAN FOR PREPAID HEALTH PLAN

	1995 Projected	1996 Projected	1997 Projected
Beginning Fund Balance	3,207,844	3,574,689	2,965,559
Revenues:			
Millage	1,488,345	1,500,845	1,546,920
Federal	37,506,349	44,089,158	44,916,029
DSHS Consolidated Funds	39,641,003	40,891,003	40,891,003
Contribution-Current Expense	399,037	359,133	323,220
General Govt-Adult Detention	91,500	91,500	91,500
Other Miscellaneous Revenue	100,000	100,000	100,000
Interest Income	94,254	94,254	94,254
TOTAL REVENUES	79,320,488	87,125,893	87,962,926
Expenditures:			
TOTAL EXPENDITURES	-78,953,643	-87,735,023	-88,015,270
Other Fund Transactions	0	0	0
Expenditure Reduction Assumption	0	0	0
Ending Fund Balance	3,574,689	2,965,559	2,913,215
Less Reserves & Designations			
* Carryover Items	0	0	0
* Other Reserves	0	0	0
Undesignated Ending Fund Balance	3,574,689	2,965,559	2,913,215
Target Fund Balance	789,536	877,350	880,153

DRAFT

PREPAID HEALTH PLAN (PHP) STRATEGIES FOR MANAGING LEGAL/FINANCIAL RISK

APPENDIX 9

	LEGAL/FINANCIAL RISK	WHAT IS AT RISK?	MANAGEMENT STRATEGY
1	More Medicaid persons who meet medical necessity criteria request service than anticipated by penetration estimates.	While some additional revenue will be generated from federal financial participation (FFP), there will eventually be insufficient State match $. The FFP and state match is lidded for adults at the Upper Payment Limit (UPL). For children it is limited only by match through the "non-risk" option.	Penetration estimates are supported by actuaries. Substantial increase in demand has been projected for the second half of 1995. If penetration exceeds estimates; proportionate case mix for non-Medicaid persons may be reduced in the next benefit period, or the case rate may be reduced. The depth to which rate cuts might extend will be spelled out in provider contracts. Medical necessity criteria will be reviewed and amended in the next benefit period, if necessary. Exception to policy reviews will be performed more frequently and stringently.
2	A reduction from the current ratio of Medicaid/non-Medicaid persons served is required to achieve revenue projections. Participation by Medicaid-eligible persons must increase.	Without sufficient Medicaid revenue to leverage State match, the PHP will not be able to finance services for non-Medicaid persons, administration, risk reserves, or other RSN services. Our model anticipates no more than 30% adult non-Medicaid and 25% child non-Medicaid. Actual data from 1993 shows approximately 60% adult non-Medicaid and 40% child non-Medicaid.	Incentives in provider contracts to make sure all persons who would be eligible for Medicaid apply and are helped through the process of becoming Medicaid eligible. Provider staff will be trained in assessing potential for Medicaid eligibility. We will contract for a case mix by funding source.
3	Medicaid eligibles are less than anticipated.	Number of Medicaid eligibles drives the Tier 1 reimbursement rate and is calculated into the UPL. Revenue will immediately be less than cash flow projections, and the UPL will be adjusted downwards by the State.	PHP will monitor the rate of Medicaid eligibles on a monthly basis. Agencies will receive minimum contracts, representing a low expectation of Medicaid participation. If Medicaid eligibles meet PHP projections, additional cases will be added to the agency contracts.

	LEGAL/FINANCIAL RISK	WHAT IS AT RISK?	MANAGEMENT STRATEGY
4	Fewer Medicaid persons than predicted present themselves for service.	Although the reimbursement for Tier 1 is dependent on number of Medicaid eligibles, reimbursement for Tiers 2 and 3 is dependent on authorized individuals requesting services. If fewer Tier 2 and 3 persons appear, revenue will be below projections. Leveraged Medicaid revenue supports; services to non-Medicaid persons, administrative costs, ongoing risk reserves, residential domiciliary care, local evaluation and treatment facilities, Involuntary Treatment Act investigatory staff and legal and transportation services, other crisis services such as crisis response system services, specialized children's services, and other special services, which are not part of the case rated benefit package.	As above, providers will receive minimum contracts which will not be increased until data shows that Medicaid Tier 2 and 3 persons are requesting services at a specific rate. A public information campaign will be conducted to increase awareness of benefit package availability.
5	Actual monthly number of Medicaid eligibles is different from historical data.	Tier 1 payments are based on monthly Medicaid eligibles.	Review Medicaid eligibility data as quickly as it is available. Work with State to develop new estimates of eligibles. In contracting with the State, negotiate for a re-opener clause if actual numbers are outside of a certain, statistically determined level.
6	Within the adult Medicaid caseload, fewer Medicare/Medicaid crossovers present for services than anticipated.	Crossovers are paid at 20% of the case rate. Savings from the full case rate allow us to serve other consumers. other projections of the number would mean less funding for distribution.	monitor the rate of Medicare/Medicaid crossovers in relation to projections. adjust the PHP system commitments and policies to reflect changes necessary. As the risk is PHP 'over projection' of crossovers, agency staff will be trained in assisting consumers to apply for Medicare.

	LEGAL/FINANCIAL RISK	WHAT IS AT RISK?	MANAGEMENT STRATEGY
7	Case mix has more authorized high service utilizers (Tier 2 and 3) than anticipated.	These users will consume more resources than we have planned for.	Tiers 2 and 3 will be centrally authorized, and monitoring against planned levels will be conducted. Trend analysis will be performed. Exception to policy procedures will be reviewed and tightened, if necessary. If usage exceeds all efforts at adjustment, the case rate may be reduced. The depth to which rate cuts might extend will be spelled out in the provider contracts.
8	Persons continue to require services after their first benefit package has expired.	The PHP cannot decline services to medically needy Medicaid eligibles, even when a benefit package has expired.	Maintain tight authorization procedures which are approved by the Medical Director. Work towards performing quality management review of agencies to determine if an earlier intervention of a different type or higher level could have prevented the need for continuing benefits. In the short-term, the case rate may need to be reduced, and the depth to which rate cuts might extend will be spelled out in the provider contracts. The wait-list policies will need to be reviewed, particularly for the non-Medicaid portion of providers committed contracts
9	Persons need services at a higher Tier level than they were authorized for.	These person will be authorized as an exception to policy if the first package is exhausted . Exception to policy resources are limited.	Tight authorization of second benefit packages and frequent review. The PHP will perform quality management review to reduce the need for exception to policy authorizations. Quality management data may result in the amendment of medical necessity criteria in the next benefit period or tightening of authorization procedures.

	LEGAL/FINANCIAL RISK	WHAT IS AT RISK?	MANAGEMENT STRATEGY
10	Children's fee for service billings are less than the UPL.	With the non-risk option, the PHP must refund the difference between children's fee for service billings (shadow billing system), less third party collections, and the UPL if the shadow billing amount is less.	Monitor children's fee for service billings and third party collections. Reduce revenue assumptions if a significant deviation from expected billings occurs. If billings do not increase, consider reducing case rate. The depth to which rate cuts might extend will be spelled out in the provider contracts.
11	Average hourly rate of return on children's fee for service billing is less than anticipated.	The PHP expects to receive an average rate of $70 for a standardized service hour. If we receive less than that due to a mix of modalities, we will get less revenue than anticipated.	Monitor children's shadow billing system and develop an "early warning" system to determine when revenues are outside of a statistically expected range.
12	Agency fails to bill a valid source of third party payments.	PHP is required to assure that vigorous efforts have been made to collect from all third party sources.	The PHP will conduct operations audits of the agencies to see that they have a procedure in place that would elicit information about any third party sources. The PHP will provide technical assistance and education to providers to help them learn to bill third parties. The PHP will use outside data sources (such as the MMIS third party liability file) to verify that agencies have found all third party sources that can be identified. The PHP may include contract incentives to maximize the rate of third party collections.

	LEGAL/FINANCIAL RISK	WHAT IS AT RISK?	MANAGEMENT STRATEGY
13	State denies a larger proportion of claims or is slower to pay than the cash flow analysis anticipates.	Poor cash flow. May have to borrow from the County or pay providers later than contractually required. Use of reserve funds for this purpose may be at risk.	PHP will develop cash flow analysis based on the best data available form the other PHPs. The PHP will work with the state prior to January 1, 1995 to debug billing routines and procedures. Revenues will be reconciled as they are received, and problems that can be resolved by fine-tuning the MIS system or clearer communication with the State will be aggressively pursued. The PHP will negotiate with the State for claims payment data and Medicaid eligibility data that is accurate and current. Access to reserve funds must be easy.
14	PHP is unable to keep a sufficient level of risk reserve funds on hand.	PHP maintains risk reserves for excess penetration and exception to policy. If these exceed planned levels, PHP may not have enough funds on hand to pay for incurred liabilities if it has to invoke the 60-day escape clause.	The PHP will hold a reserve of $5,500,000 made up of two components: $3,000,000 to cover excess utilization which will include exception to policy (unprojected demand) and risk associated with the Western State Hospital Risk Pool Agreement. $2,500,000 in a one time only reserve. The total of the risk pool is 10% of the Medicaid/non-Medicaid case rated services.
15	System demand is greater than the capacity to deliver services.	Certified agencies who have contracts to provide services are not able to gear up to meet extra demand.	We will develop vendor agreements with certified providers. These agreements will not constitute a contract for services, but will permit us to enter into a contract with the vendor when we need to more service capacity. We will need to have a swift and responsive contracting mechanism to allow us to put these resources in place when they are needed.

	LEGAL/FINANCIAL RISK	WHAT IS AT RISK?	MANAGEMENT STRATEGY
16	By taking on an authorization function, the PHP assumes the risk of denying a benefit package to persons with valid medical need.	Liability for not properly serving individuals, both those who are part of an entitlement system, and others who have previously been defined as a population to be served with public funds. In addition, there is the potential for a litigation process to set aside the PHP's authorization criteria and process and leave the PHP with no means to control utilization rates and expenditures.	PHP Medical Director is responsible for final sign-off on criteria for medical necessity and authorization procedures. There will be a system for automatic review of all denials by authorization staff before they are communicated to the agency that requested authorization. In addition, there will be grievance processes managed through both the PHP grievance procedures and an Ombuds function. Utilize authorizers who are clinicians and maintain specialists on staff. Train authorizers thoroughly. Develop procedures and validate tools for agencies to conduct assessments and present their assessments to the County authorizers in a cogent and cohesive format. Provide a monitored wait list for all Tiers except 1a, with limited wait periods, prioritize within the list, and ability to contract for additional system capacity, if funds are available. Educate system personnel on alternative resources for persons who are denied access to the mental health system. Complete authorization of all current consumers prior to January 1, 1995. In concert with provider agencies, develop transition procedures to cause the least disenfranchisement to consumers. Minimize consumer disruption. Conduct a public information campaign to make consumers, families, and advocates aware of changes.
17	Initial consumer enrollment/provider assignment process results in grievances.	If consumers or providers do not feel that their concerns with system change are being addressed, they may have grounds for an injunction.	PHP will conduct a public information campaign to inform consumers of their rights and the process for enrollment. The PHP will work with providers to educate them on a managed care system and attempt to make the transition period as smooth as possible. The PHP will work with providers on transition planning, so that consumers do not experience unnecessary disruption. Grievance procedures will be communicated to all consumers.

	LEGAL/FINANCIAL RISK	WHAT IS AT RISK?	MANAGEMENT STRATEGY
18	Agencies are not able to manage cases within the benefit packages developed.	Agencies are unable to move from a fee for service strategy to a managed care strategy. They fail to balance case rates with the level of service they provide.	This is a consumer and an Provider risk; PHP will provide technical assistance, share system/provider data, and offer education and training to agencies. We will determine if there are any circumstances where the PHP would provide a bail-out for a failing provider, but we have no current plans to provide a stop loss arrangement. Agencies will be contractually required to have a credible utilization review/management program in place when PHP services begin. PHP will perform ongoing quality management to determine the source of problems and to review and modify benefit packages, as necessary.
19	PHP denies or provides service based on an out of date eligibility information.	State Medicaid eligible information may be out of date.	PHP will develop MIS links to eligibility information, either at State or local CSO level. PHP will advocate with State to make currency of eligibility information a priority.
20	Western State Hospital (WSH) In-Residence Count (IRC) grows above target values.	PHP will pay a negotiated penalty for failing to reduce the census.	Maintain risks and rewards in provider contracts to aggressively attack problems in the WSH IRC when they occur. Control of voluntary hospital admissions will help mitigate.
21	Native Americans qualify for the Native American exemption and we must maintain a fee for service structure for adults as well as for children.	It may be federally mandated that Native Americans will have the freedom to choose to receive their medically necessary services outside of a managed care system. If this is the case, it may require maintaining a fee for service system within the RSN, and will require payment to providers outside the PHP network	If the services were paid on a fee for service system, they could not be case rated. This would require estimates of the demand for services, adjusted by 1995 estimates of penetration. A set-aside fund would be created for these services and a fee for service billing system will be maintained. Clarification is currently being sought from the State on whether care can be managed on a case rate basis on line with PHP managed care

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May 18, 1994

Lynn Davison
King County Mental Health Division
Department of Human Services
506 Second Avenue, Suite 512
Seattle, WA 98104

Dear Lynn:

Re: Review of financial model and risk strategies

As you requested, we have reviewed your financial model and risk management strategies for reasonableness. In this letter, we respond to your questions regarding the reasonableness of your approach. While we have reviewed the basic assumptions, we have not checked the mathematical calculations in the model. Overall, we believe you have done an excellent job of assessing the risks that KCRSN will face and developing a process for managing that risk.

Review of Assumptions

1. Annual Medicaid Eligibles

   A: Based on the information provided, the assumption of 91,971 adults and 125,249 children appears to be reasonable. You may be able to get more updated information on Medicaid enrollment levels from the State as you move closer to implementation.

2. Penetration Rate: Adults 12%, Children 8.7%

   A: We continue to think these assumptions are reasonable. However, we believe the rate of change from current levels to the new higher levels may be slower than that assumed in the financial model. Industry standards suggest an approximate two to three year period is required for a full change in penetration levels from a system that has previously been restricted (such as the current mental health program) to one that will have fewer barriers to entry. This change in penetration levels is based on normal marketing practices as compared to highly aggressive outreach. For children in particular, we believe the total increase in penetration rate will occur over 2 to 3 years, with penetration rates moving to approximately 5% in the first year, 7% in the second year, and 8.7% in the third year. The change in the adult rate is not as dramatic and so may occur sooner (i.e., 1 to 2 years).

3. Case mix by tier

   A: We agree with the direction of your assumption that new users are likely to require services at lower levels than your current users. We don't have the ability to assess the actual numbers but assume they are based on your medical necessity analysis.

4. Medicare crossover payments: 20% Medicaid/80% Medicare

   A: The assumptions made here appear to be appropriate.

5. Children's "risk status": no risk

   A: We agree with your decision to provide children's services on a "no-risk" basis. The children's services are likely to have the greatest increase in utilization and risk over the near term.

6. Percent non-Medicaid: 30% adults, 25% children

   A: We agree with the direction of your assumption that non-Medicaid recipients will make up a smaller percentage of your total users as efforts are made to aggressively qualify people for Medicaid. We understand that the total number of non-Medicaid users is not expected to decrease. We have no way to directly assess the 30% and 25% assumption.

7. KCRSN Administration: 5%

   A: We believe it will be difficult but possible to bring administrative costs down to 5% from 6.5%. We understand that total administrative dollars will increase because more dollars are being added to the base. However, it is important to note that KCRSN will have a number of new administrative responsibilities, including claims administration, system oversight, and provider contracting. Industry standards for administrative costs for monitoring managed mental health programs are in the range of 6% to 8% of total funds.

8. Risk Reserves

   A: See detailed review of risk reserve issues below under item 13.

9. RSN Services

   A: We don't have a way of assessing these issues.

10. Benefit Package

A: We agree with your assumption that aggregate average hours per user will decrease. This decrease will result both from the managed care effect and the change in the risk mix of your enrollees.

11. Standard hourly rate

A: We have reviewed the methods used for calculating the $63.00 as a standardized hourly rate for both adults and children and agree with the basic methodology. Based on other sources of information, we believe it is appropriate to assume the same payment level for adults and children. It would, however, be appropriate to monitor the mix of services provided to adults and children to determine whether there is a difference in the types of services provided and the impact of any difference on the average standardized hourly rate.

In response to your question regarding using the median or weighted mean for the calculation, the weighted mean is generally the preferred method as this provides a more accurate measure of likely future costs. However, there can be valid reasons for using the median if, for example, the distribution of costs is highly skewed. In addition, using the median may provide a more conservative value if it is slightly higher than the weighted mean.

12. Calendar Year versus Rolling 12-Month Average

A: Using a rolling 12 month average may change the results, since more users would be expected to hit any benefit maximums if their benefits are counted for 12 months from the first date of service. For example, if services are counted from the date a person first uses a service, 12 full months of service would always be available. Alternatively, under a calendar year system, a person who first uses services towards the end of a year would have a limited ability to use the maximum service level. Administrative costs may be higher under a calendar year system, since people who initially become eligible towards the end of the year would need to be reauthorized at the start of the next year. Utilization rates may also be slightly higher under a calendar year system since there may be a push to "use up" services before the benefit period expires.

13. Risk Reserves

A: We believe the amount you have allocated for reserves will be adequate provided 1) there is careful monitoring of utilization levels and 2) you have the ability to reduce case payment rates by as much as 10% if utilization rates are above projected levels.

Your risk management strategy appears to be sound. In particular, the full transfer of risk on per case costs will be helpful in managing the RSN's total risk, since you will bear risk only for penetration rates and case mix. Under item #5 "Persons continue to require services after their first benefit package has expired," we would recommend that if exceptions are being made in more than 5% of the cases that a thorough review of assignment criteria be made.

To manage exceptions actuarially, you will need to make assumptions regarding the frequency of policy exceptions and then fund those cases through a reserve. Since you have already estimated the per case cost by tier, it is now necessary to estimate the percentage of exceptions with some margin for error. The general rule for margin of error (which translates into a reserve level) is roughly 10% of annual funds. This is almost exactly the amount you have designated for a reserve. However, as noted above, if through monitoring you find you are making exceptions in more than 5% of the cases, you will need to consider changes in your operations.

Because the amount of funds that will be spent from the reserve is by definition unknown, we can't predict precisely how much will be available for bonus payments. However, we would recommend that you ultimately fund a reserve of approximately 10% of total annual liabilities. This could be done over several years, with 50% of the remaining reserve in the first year used for bonus payments and the balance funded from future revenues. The second year you may retain 50% of the additional amount allocated to reserve, and so on until you hit your target level.

14. To perform a cash flow analysis in 1995, we would require data on 1) the seasonality of providing services (i.e., do more services get provided at certain times of the year; 2) your contract arrangements with all of your providers; 3) administrative costs; and 4) information on waiting lists by tier. The resulting analysis (if it is to be prospective) would have roughly the same level of credibility of the work you have already done. Since no additional information is available right now, the value of a cash flow analysis would be limited from an actuarial perspective. However, a cash flow model would be useful from an operational perspective for determining the expected distribution of money and would provide a tool for monitoring actual experience.

* * * *

Lynn, I hope these comments are useful. Please call me at 415-957-3330 if you would like to discuss them further.

Sincerely,

Sandra Hunt

Sandra Hunt

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February 17, 1994

Ms. Joanne Asaba
Assistant Manager
King County Department of Human Services
Mental Health Division
506 Second Avenue - Room 512 Smith Tower
Seattle, WA 98104

Dear Joanne:

Re: Proposed Capitation Rates

As you requested, we have reviewed the State's proposed payment levels and expected utilization levels for the Medicaid Mental Health Managed Care program. This letter reports on the results of that review and highlights our concerns with the methods used to calculate the payment rates. We also discussed important areas of risk that King County Regional Support Network ("KCRSN") should consider as subcontract arrangements are developed.

Background

The State of Washington is in the process of implementing a capitated payment system for Title XIX mental health services. Under the program, each Regional Support Network (RSN) is expected to contract with the State at a capitated rate to provide all outpatient mental health services. The State is also considering whether to contract on a capitated basis for inpatient services. According to State Division of Mental Health staff, the capitation rates have been developed to retain the current distribution of funds by geographic area relative to their estimate of costs under a fee-for-service system, with an expected 1% overall savings in the system. Six separate rates for each RSN have been developed, with rates for three "tiers" of clients and separate rates for adults and children.

Following the initial capitation rate development a number of questions were raised regarding the completeness of the data and the methods used in calculating the rates. While no changes in the basic methodology for calculating the rates were promised, the State agreed to recalculate the rates using more recent data and to consider making adjustments for claims that had been incurred but were not reported in the claims system at the time the analysis is done.

Proposed Payment Rates

In their most recent calculation of payment rates for the program, the State has proposed the following amounts for King County RSN:

TABLE 1

PROPOSED MONTHLY PAYMENT RATES - FY 1994

	ADULTS			CHILDREN		
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Categorically Needy	$1.26	$205.94	$813.61	$0.66	$511.87	$1911.80
Disabled	3.62	409.46	1356.66	1.83	810.94	1952.64
Medically Needy	1.07	235.91	1288.69	1.05	636.72	N/A
All	2.05	358.87	1290.69	0.69	539.96	1916.98

Under this payment arrangement, KCRSN will be paid a monthly capitation amount for each person in your geographic area qualifying for Medicaid. Additional payments will be made for people requiring higher levels of service. Those people have been termed tier 2 and tier 3 users. KCRSN is limited in the total number of tier 2 and tier 3 users it will be reimbursed for based on the historical proportion of high service users in the population. In other words, if the total size of the Medicaid population grows, KCRSN will receive additional reimbursement. If the mix of users changes, so that a higher proportion uses any services, or the proportion of the population requiring high levels of services increases, KCRSN will be expected to meet those additional service requirements within the fixed upper payment limit.

Methods Used for Calculating the Payment Rates

The payment rates were calculated by Milliman & Robertson. Their initial report describing their methods was prepared January 8, 1993. Updated payment rates were provided January 14, 1994, but we understand that a new report has not been produced. Therefore, we have assumed that the same basic methods were used for calculating the rates, with two exceptions:

1) More current data were used (Calendar Year 1992 compared to Fiscal Year 1992); and

2) A factor of 0.9% was calculated and applied to account for claims that were incurred but not reported at the time the analysis was done. This 0.9% is a reasonable adjustment factor given the length of time between the data reporting period and the analysis period.

Assessment of Actuarial Methods

Coopers & Lybrand performed an initial review of the methods used for developing the capitation rates under a contract with Spokane Community Mental Health Center. The two changes made to the methods partially responded to our concerns reported in a letter to Mary Higgins dated April 7, 1993. Use of more current data allows for recognition of the impact of important federal policy changes on the average payments for tier 2 and tier 3 clients. Application of an IBNR factor is a standard actuarial practice used to estimate total costs given the time lag between when services are provided and final payments are made. However, we continue to have concerns regarding the relationship between the criteria used to develop the payment rates (particularly for tiers 2 & 3) and the criteria that will be used to make payments under the proposed contract.

We understand that a task force of practitioners was created in King County to develop criteria for determining the medical necessity of specific service levels. That work group assessed the relationship between people who were identified as high utilizers in the pricing methodology and those that would be classified as tier 2 or tier 3 eligibles under the proposed contract language. According to their report, dated October 6, 1993, the state's tier 2 criteria would result in 48% of KCRSN users being classified as tier 2 compared to 42% based on the pricing methodology. The difference for tier 3 are more substantial, with less than half of the tier 3 clients identified appropriately (29% versus 13%). This important mismatch in criteria is a significant issue in determining the appropriateness of the payment methods and amounts. In fact, based on this analysis, there does not appear to be sufficient linkage between the rates that will be paid for high cost users and the actual cost (either historical or in the future) of the people who will be classified as tier 2 or tier 3.

We understand that the total payments under the capitated program are constrained by the upper payment limit. As a result, the State has assumed that RSN's will serve the minimum number of tier 2 and tier 3 clients necessary to obtain 100% of the allowable reimbursement. RSN's are then at risk for any additional utilization. In our opinion, any match in the proportion of users who require tier 2 and tier 3 levels of service and those used for the rate development would appear to be only coincidental.

Another issue is whether the Group Health Cooperative Medicaid enrollees were included in the count of eligibles in King County. We understand that the mental health services currently provided by Group Health Cooperative will become the responsibility of KCRSN. We further understand that the current costs for those services are not included in the claims data base. If

this is the case, and the GHC enrollees were included in the count of eligibles for calculating the capitation rates, the tier 1 rates may be understated by as much as 10%.

Pricing Assumptions

The KCRSN work group has developed pricing and cost models to estimate the likely costs of serving the Medicaid population under a capitated system. Important assumptions in those cost models relate to:

1) The number of people who will require any service (the penetration rate);

2) The number of people who will require high levels of service (the severity rate); and

3) The numbers of services that will be required for people with different levels of severity (the use rate).

To assess the cost assumptions made by your work group, we have attempted to gather data from other mental health programs across the country regarding such things as penetration rates and use rates. We received some data from New York State, Philadelphia, Utah, Massachusetts and Arizona. The Arizona data was not comparable to the other data sources, but the other information is useful for comparison purposes. We also report on utilization rates based on data we developed for pricing the mental health component of the Oregon Health Plan Medicaid Demonstration to estimate average utilization levels for a mental health program. In reviewing the utilization numbers, it is important to recognize that the data sources are different and both the classification and means of counting services vary for the different programs. Significantly more time would be required to permit a more thorough data analysis, including obtaining a clear understanding of the way units of service are counted. Where information was readily available, we have noted how units of service were counted. The attached Table 3 shows a comparison of utilization rates for various mental health services for a number of programs. The data for King County RSN are based on reports provided by the State of Washington.

Because of the unique characteristics of the proposed Washington program, comparable data do not exist on the number of projected users for each tier broken out by adults and children. In fact, we are not aware of any other program that uses such a tier pricing methodology. Therefore, the data analysis done by the State and the work done by your work groups to assess the service level needs of your clients is the best available information at this time. However, some general studies on the prevalence of mental illness for different population groups and the likelihood that a person needing mental health services will actually use services in a given year, such as the Epidemiologic Catchment Area[1] study, can provide some reasonable estimates on the overall demand for mental

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[1] Robins, Lee N. and Darrel A. Regier, Psychiatric Disorders in America, the Epidemiologic Catchment Area Study: New York, 1991

health services. More recent studies have also been reported in the press, but were unavailable from the publishers when we requested them.

According to the ECA, approximately 8.7% of Medicaid children and 12% of Medicaid adults will require any mental health services in a year. The ECA studies do not report on the demand for varying levels of services that would fit within the tier classifications used in Washington. However, the following table shows the expected prevalence of the most common or high cost diagnoses. The table also shows the prevalence of the diagnoses for clients served by KCRSN in 1992. Within each diagnosis clients may need either tier 1, tier 2, or tier 3 levels of service. We believe that the ECA data in combination with information you have gathered from other mental health programs provides the best indication of likely demand levels when services are not constrained by available funds. The experience in Utah under the managed care program has been significantly different from what would be expected based on the ECA data, particularly for adults. Specifically, data provided by that State indicate that 29% of adults and 11% of children have used some mental health services. We believe these numbers warrant further investigation, as there may be differences in how Utah has counted users compared to the methods used by the ECA.

Because of the dramatic difference in penetration rates for children in particular, we would expect that the increase in utilization would occur over a period of years, depending on the level of your outreach efforts. For example, in developing cost estimates for the Oregon Health Plan for physical health services, the Oregon Medical Assistance Program office assumed a three year phase-in. We are not aware of comparable phase-in statistics specifically for a capitated mental health program, although first year experience is reported in Utah. In that program, there was an approximate 35% increase in the overall percentage of clients receiving any outpatient services in the first year of the capitated program. There was also a decrease in the amount of services used per client served.

Actual experience in King County will depend on how the program is communicated to potential clients and whether services can be made available immediately. However, in assessing likely costs to the system it is also important to keep in mind that even if sufficient service capacity does not immediately exist within the public system to meet demand, KCRSN will be responsible for the costs of all services, including services that must be provided through private practitioners on a fee--for-service basis.

TABLE 2

King County Regional Support Network
Prevalence of Major Diagnoses in Epidemiologic Catchment Area Study
Poverty Population and King County RSN Historical Data

CHILDREN

	E C A data				
	Episodes per per 100 Population	Case Distribution	Cost Distribution	King County Episodes per 100 Population	King County Case Distribution
Major Depression	1.02	12%	6%	0.12	7%
Bipolar Disorders	0.00	0%	1%	0.02	1%
Post-Trauma Stress	0.59	7%	12%	0.25	15%
Schizophrenic Disorders	0.01	0%	3%	0.03	2%
Anxiety Disorder Unspecified	0.01	0%	2%	0.17	10%
Adjustment Disorders	0.36	4%	21%	0.50	29%
Borderline Personality	0.00	0%	1%	0.32	19%
All Other	6.69	77%	55%	0.91	17%
Total	8.68	100%	100%	2.30	100%

ADULT

	E C A data				
	Episodes per per 100 Population	Case Distribution	Cost Distribution	King County Episodes per 100 Population	King County Case Distribution
Major Depression	1.42	12%	15%	1.50	16%
BiPolar Disorders	0.78	7%	15%	0.87	10%
Post-Trauma Stress	0.59	5%	1%	0.20	2%
Schizophrenic Disorders	0.16	10%	42%	2.01	22%
Anxiety Disorder Unspecified	0.14	1%	3%	0.56	6%
Adjustment Disorders	0.30	2%	6%	0.45	5%
Borderline Personality	0.70	6%	1%	0.06	1%
All Other	6.95	58%	17%	4.25	38%
Total	12.02	100%	100%	9.90	100%

The State has assumed that approximately 9.9% of adults and approximately 2.3% of children in the Medicaid population will require any mental health services in a year. Those numbers are substantially below the numbers suggested by the ECA studies. The prevalence of need for children, in particular, appears to be understated. We understand that the State's estimates are based on historical use patterns. We also understand that children's services have been under-funded in the past and that access to services has been limited.

We would conclude that KCRSN is at significant risk for additional utilization when the rules for accessing services are changed and the RSN is required to provide all medically necessary services as compared to only those services that are funded by the State. However, in assessing the impact of additional demand for services, the cost per user should be adjusted downward from the historical levels, as we would expect that many of the new users will require relatively low levels of services compared to your historical client base. Based on the "priority" finding methodology, we believe that you have historically served a disproportionately high cost mix of clients compared to the overall Medicaid population. However, to the extent that historical funding levels have not allowed for treatment of the most severely mentally ill, additional costs for this population may also be incurred. A needs assessment would need to be conducted to determine the most likely configuration of users relative to historical utilization levels.

To determine the level of financial risk we recommend that you run a range of assumptions through your pricing model. Specifically, we would assume a total penetration rate of 12% for adults and 9% for children. We would further assume that most of the additional utilization will be in tier 1 but that some small portion of users will move up to tier 2 or tier 3. This could be modeled by assumed that 90% of the new users are in tier 1, with the same average number of service hours as occurs in the current tier 1 population. The remaining 10% would be distributed in the same proportion as current tier 2 and tier 3 clients. A second modeling would assume that 80% of the new clients are in tier 1 and the remaining 20% are distributed to tiers 2 and 3. Finally you could assume that 95% of the new users are in tier 1 with the other 5% going to tiers 2 and 3.

Relationship Between Inpatient and Ambulatory Utilization

The proposed contract covers ambulatory services only. However, we understand that the State is considering expanding the contract to include inpatient services depending in part on the interest level of the Regional Service Networks. In other words, KCRSN would be paid a capitation rate that is intended to cover all mental health services required for the Medicaid population, rather than restricting the capitation contract to outpatient services.

We understand that there has historically been relatively low inpatient utilization in King County, resulting in part from a shortage of available beds. We also understand that a number of beds have become available recently and that occupancy rates have been reduced, due in part to additional private hospitals contracting with Medicaid to provide inpatient services. According to data supplied by the State, inpatient utilization in King County has averaged 280 days per 1000

members per year, and 22 admissions per 1000. These figures compare to an average utilization rate of 163 days per 1000 members in the Oregon Medicaid program for mental health services. However, the Oregon numbers exclude all people with lengths of stay in excess of 30 days, so they are significantly different from the numbers reported by the State of Washington. Inpatient days in New York and Philadelphia are both higher than the KCRSN utilization numbers. Based on this data, it is unclear whether there is significant room for reducing the utilization of inpatient services in King County.

Risk Considerations

It is important to recognize the difference in the nature of the contractual arrangement between KCRSN and the State compared to the historical arrangement. In the past, the State essentially determined the number of people that KCRSN was responsible for serving in a given time period. To the extent that demand for services exceeded the budgeted supply, KCRSN did not have an obligation to provide the services and potential clients could be placed on a waiting list. Under a capitated arrangement, KCRSN is contractually obligated to provide the services, and historical patterns of underfunding are not taken into account in developing the capitation rates. In fact, under federal regulations, the State is limited in the payments it can make to the fee-for-service equivalent cost of providing services to an actuarially equivalent population. Therefore, little change could be made to the total payments expected to be made to the RSN unless other fundamental changes are made in the fee-for-service budgeting process. Still, the potential risk to the RSN is significant.

KCRSN is at considerable risk for additional utilization beyond the historical levels for the services covered by the proposed capitation contract. We believe the greatest risk is that greater utilization will occur in the tier 1 population. According to data supplied by the State, only 9.9% of adults and 2.3% of children in the Medicaid population obtained any mental health services in 1993. These utilization levels are significantly lower than those that would be implied by the ECA studies.

Additional utilization may also occur for tier 2 and tier 3 eligibles. In particular, the mismatch between the criteria used for classifying an individual as tier 2 or tier 3 for pricing purposes and what will be used in the contract represents significant risk to the RSN. However, we believe that KCRSN will have greater ability to control this utilization, as this is the population you have largely served in the past. You also will have the ability to determine the amount of services to provide based on your assessment of medical necessity. It will be in your financial interest as well as the interest of your clients to provide services that result in improved outcomes and health maintenance. For the tier 1 population, for which you will receive a capitation rate, you will have no real control over the number of people who demand services. This represents a real financial risk to KCRSN if effective methods are not in place to control initial assessment of client needs and entry into the systems.

The design of the program excludes inpatient services from the capitated arrangement. This design removes some of the flexibility KCRSN might have in managing care. In fact, under most managed mental health programs, transfer of patients from inpatient to outpatient care is the source of most of the savings. Improved management of outpatient care also results in substantial cost savings, but it is critical that there be some room for moving people from one level of care to another for cost savings to occur. Without further analysis of service delivery patterns in King County we are unable to make a firm recommendation regarding a capitation arrangement for inpatient services. However, it appears that utilization rates are relatively low compared to other mental health programs and that it may be difficult to achieve additional savings.

* * *

Joanne, I hope these comments are helpful. I am available to discuss these pricing and contracting issues should you wish to do so, and can be reached at 415/957-3330.

Sincerely,

Sandra Hunt

Sandra S. Hunt, MPA
Senior Consultant

King County Regional Support Network

Table 3

Comparison of Mental Health Services Utilization and Cost Rates

	State of New York Adults	State of New York Children	City of Philadelphia Managed Care	City of Philadelphia Fee for Service	State of Mass. Adults	State of Mass. Children	State of Utah Adult Units	State of Utah Child Units	State of Utah Total Population	State of Oregon Adults & Children	King County RSN Adults	King County RSN Children
Inpatient												
Cost per Day	$395.93	$496.66	$384.59	$354.90	$439.00	$542.00	N/A	N/A	$567.12	$400.00	$321.77	$324.05
Users per 1000	N/A	N/A	12.97	19.68	16.00	16.00	1.26	5.79	8.60	N/A	16.65	3.09
Days per 1000	877.12	128.10	304.32	484.68	780.00	109.09	291.38	133.35	198.78	163.00	250.53	135.83
Admits per 1000	35.83	4.16	N/A	N/A	66.73	7.05	16.43	6.39	10.54	N/A	28.27	4.72
Cost PMPM	$28.94	$5.30	$9.75	$14.33	$28.54	$4.93	N/A	N/A	$9.39	$10.94	$6.72	$3.67
ALOS	24.48	30.78	23.46	24.63	11.80	17.30	17.74	20.89	18.85	N/A	8.86	28.80
Outpatient												
Psychotherapy												
Cost per Unit	$410.07	$263.62	$24.82	$24.00	$65.00	$65.00	N/A	N/A	$62.01	$55.68	$83.39	$116.55
Users per 1000	N/A	N/A	98.90	101.60	130.00	130.00	294.34	115.03	189.26	N/A	160.50	41.79
Units per 1000	1,835.61	570.25	1,150.54	1,184.22	N/A	N/A	6,382.60	1,938.49	3,778.38	1,820.00	5,098.07	928.48
Cost PMPM	$62.73	$12.53	$2.38	$2.37	N/A	N/A	N/A	N/A	19.52	$17.66	$35.43	$9.02
Residential Care												
Cost per Unit	$222.33	$2,381.58	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Users per 1000	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Units per 1000	309.93	14.95	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cost PMPM	$5.74	$2.97	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Day Program												
Cost per Unit	$83.52	$92.92	$6.58	$6.25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Users per 1000	N/A	N/A	20.24	27.94	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Units per 1000	1,976.14	243.40	5,938.80	9,222.46	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cost PMPM	$83.52	$1.88	$3.26	$4.81	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Notes:

N/A=Not available

For the State of Massachusetts, inpatient users per 1000 and outpatient values are calculated for the entire population, as data were not available separately.

For KCRSN, Psychotherapy includes clinic services, outpatient hospital services, psychiatrist services and psychologist services. Users per 1000 for outpatient services may be overstated if the same client uses multiple types of services.

KCRSN data is approximately 85% complete. In other words, actual utilization rates are approximately 17.5% higher than those shown here.

King County Regional Support Network
Comparison of Mental Health Services Utilization and Cost Rates
Definitions

New York State

Outpatient Psychotherapy Units: 1 unit = 1 visit (could be anywhere from 15 minutes to 1 hour)
Eligibility included: All aid categories including Home Relief

City of Philadelphia

Outpatient Psychotherapy Units: 1 unit = 1 hour (adjusted from 30 minutes)
Eligibility included: Fee-For-Service population - all aid categories with nominal representation of Aid to Families with Dependent Children (excludes managed care population)

State of Massachusetts

Outpatient Psychotherapy Units: 1 unit = 1 hour
Eligibility included: Mostly Aid to Families with Dependent Children

State of Utah

Outpatient Psychotherapy Units: 1 unit = 1 hour (adjusted from 15 minutes)
Eligibility included: All categories except people in state hospitals

State of Oregon

Outpatient Psychotherapy Units: 1 unit = 1 hour
Eligibility included: All aid categories

King County RSN

Outpatient Psychotherapy Units: 1 unit = 1 standardized service hour
Eligibility included: All aid categories

King County Regional Support Network
Comparison of Mental Health Services Utilization and Cost Rates
Data Sources

State of Utah

State of Utah Department of Health Division of Health Care Financing, waiver renewal request. Dated September 3, 1993.

State of New York

Bureau of Financial Planning, New York State Office of Mental Health
Telephone Interview, Norman Brier , Director
Barry Brauth, Assistant Director

City of Philadelphia

City of Philadelphia Health Commissioner's Office
Telephone Interview, Estel Richman, Acting Health Commissioner

State of Massachusetts

State of Massachusetts Medicaid
Telephone Interview, James Michel, Director

Oregon Health Plan, Medicaid Demonstration

Analysis of Federal Fiscal Year 19994 & 1995 Average Costs, Coopers & Lybrand

King County RSN

Utilization reports, run date 1/7/94
Recast of King RSN Title XIX Eligibles & Claims Lag Analysis, dated 12/2/93
Unduplicated user counts, memo from Ron Kero dated 1/26/94
PHP Pricing Models dated 11/30/93 and 9/6/93
Estimated Title XIX Eligibles and Total Upper Payment Limit, SFY 94 & 95, dated 1/14/94
KCRSN Inpatient utilization data, memo from Lynn Davison dated 1/14/94
Coordinated Community Mental Health Preogram Request for Waiver, Actuarial Calculations, Milliman & Robertson, 1/8/93
SPSS report on KCRSN Users by diagnosis dated 5/18/93

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February 17, 1994

Ms. Lynn Davison
Manager
King County Department of Human Services
Mental Health Division
506 Second Avenue - Room 512 Smith Tower
Seattle, WA 98104

Dear Lynn:

Re: Response to Questions on Review of Capitation Rates

We have included in the enclosed report many of the comments and responses to questions raised in your letter of February 14th. However, I thought it would simplify things to also respond to the questions in a separate document.

Unfortunately, the size of our contract, which was limited to 40 hours of consulting time including time for collecting and reviewing documents and inputting data, does not permit some of the analysis you are requesting. In particular, we have not constructed a cost or pricing model and recommend that the assumptions that we discuss be used to work with the pricing model that your work group has already developed. Because of the limited funding that was available, we also agreed that KCRSN staff would have responsibility for gathering the necessary data. We would be happy to perform the more detailed analysis that you discuss, but would require a modification to our contract.

I hope the following information is helpful in assessing the costs and benefits of entering into a capitated contract with the State. We have combined several of the questions because the answers are related.

1. *Based on your review of the claims lag data we supplied, does Milliman and Robertson's 0.9% IBNR adjustment appear to be adequate? If no, what should it be?*

   We believe the 0.9% adjustment factor is appropriate given the time lag between the data collection period and the data analysis period.

2. *Could you add the Utah and Massachusetts data to your comparisons?*

The data have been added. Both sets of data were obtained after we completed the previous draft of the report.

3 & 6. *The CPC study regarding the appropriate mix of PHP adults across tiers suggests a much higher proportion of the caseload requiring the more intense service levels. Could you look at the CPC data in light of information/experience you have? If you disagree with their findings, what would be your best estimate of case mix?*

We were curious about your conclusion that in assessing the impact of additional demand for services, the cost per user should be adjusted downward from historic levels. What did you base this on? Do you believe it true for both adults and children?

In assessing the likely distribution of clients by tier and service demand level, and in particular, the likely level of change in demand, it is important to first understand the methods that have been used for identifying clients and service requirements in the past. Without conducting a detailed analysis of the current circumstances, we must rely in part on your assessment of how services are delivered in King County to make this determination.

While we agree with the CPC study that the classification methods used by the State to identify potential tier 3 clients does an inadequate job, we would need to have additional information regarding the way that you would treat the same patients in the future to have a better understanding of the likely cost impact. For example, if you believe that you have treated clients at the level of services required to meet medical necessity, we would not expect costs to increase significantly for your historical client base. However, if you believe that provision of services even for the most ill patients has been below the levels indicated by medical necessity, then we would expect costs to increase for this group.

Our understanding is that mental health services are funded by the State on a "priority" basis, with funding going first to the most severely mentally ill and then moving downward, so that the last groups to be funded are those with the lowest level of need. We also understand that the budget constraints have served largely to restrict access to initial services, but that once clients enter the system they generally use services at appropriate levels. This is why we believe that under a capitated system the average cost per user will decrease, as those with lower need levels enter the system. This assumption does not mean that we expect overall cost per Medicaid eligible person to decrease, since we expect the

total number of users to increase, but that the mix of users will change to more accurately reflect the mix of need in the Medicaid population.

As noted in our report, we are not aware of other programs that are funded on a tier basis and do not have access to data that would reflect the mix of need by tier. However, we believe that the modeling that is often done in the budget process by many states could be helpful in assessing the numbers of people with varying service demand levels. We would recommend that you contact people at different states and pool whatever information is available. We would happy to undertake this research through a modification to our contract if you so desire.

4 & 8. We must settle on a projected outpatient penetration rate. Are we correct in assuming that your best statistics are 12% for adults and 9% for children. Is this based solely on the ECA data?

We are interested in the percentage growth in penetration as systems move from fee for service to capitation. Can you provide any data on the percentage growth in other states and give us your best estimate of a reasonable growth rate for the first three years for kids and adults in King County?

The best information we have available on general demand levels for a Medicaid population under a system that is not constrained by the priority funding process is from the ECA. More recent research has been completed, but those reports have not yet been distributed. Therefore, we believe that the 12% penetration rate for adults and 9% for children are the best available numbers. However, we are aware that the Utah capitated program has seen penetration rates that are higher than these, with 29% for adults and 11% for children. We believe it would be worthwhile for you to discuss the differences and similarities in the proposed program in Washington and the Utah program to get a better understanding of likely penetration levels. In particular, it would be worth understanding the methods used for counting users, since the numbers for adults in particular are so far above the expected values.

Because of the dramatic difference in penetration rates for children in particular, we would expect that the increase in utilization would occur over a period of years, depending on the level of your outreach efforts. For example, in developing cost estimates for the Oregon Health Plan for physical health services, the Oregon Medical Assistance Program office assumed a three year phase-in. We are not aware of comparable phase-in statistics specifically for a capitated mental health program, although first year experience is reported in Utah. In that program, there was an approximate 35% increase in the overall percentage of

clients receiving any outpatient services in the first year of the capitated program. There was also a decrease in the amount of services used per client served.

Actual experience in King County will depend on how the program is communicated to potential clients and whether services can be made available immediately. However, in assessing likely costs to the system it is also important to keep in mind that even if sufficient service capacity does not immediately exist within the public system to meet demand, KCRSN will be responsible for the costs of all services, including services that must be provided through private practitioners on a fee--for-service basis.

5. *You suggested that the PHP will have significant financial exposure, particularly for tier 1. It would be helpful to get ballpark estimates of financial risk by tier for adults and children.*

We recommend that you run the assumptions we have identified through your pricing model to assess the likely financial risk. Specifically, we would assume a total penetration rate of 12% for adults and 9% for children. We would further assume that most of the additional utilization will be in tier 1 but that some small portion of users will move up to tier 2 or tier 3. This could be modeled by assumed that 90% of the new users are in tier 1, with the same average number of service hours as occurs in the current tier 1 population. The remaining 10% would be distributed in the same proportion as current tier 2 and tier 3 clients. A second modeling would assume that 80% of the new clients are in tier 1 and the remaining 20% are distributed to tiers 2 and 3. Finally you could assume that 95% of the new users are in tier 1 with the other 5% going to tiers 2 and 3.

7. *In Table 3, the cost per unit of service on the outpatient side varied dramatically. We expect this may be due to different definitions of unit and perhaps to different population bases. Could you provide common unit definitions or at least a way to cross walk the data? Is it possible to compare our standardized cost per service hour of $63 for adults and $70 for children with any of the data you have? Could you also describe the covered eligibility groups?*

We agree that the significant differences in definitions of units of service exist in the different data sources. In particular, the standardized service hour used in Washington is not used in other states. We have attempted to identify the definitions used by the various states that provided us data and have noted the definitions where they were available. This information is included in the revised Table 3.

9. *Could you list for us all data sources you have used for your analysis, including those that you received from us?*

   The data sources are noted in the appropriate tables.

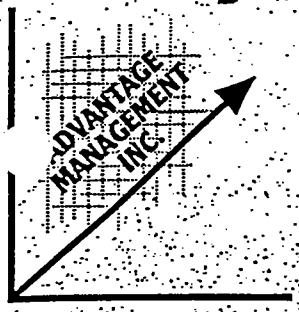
* * *

Lynn, I hope these responses answer the questions you and your work group have. Because the Washington program is unique it is difficult to translate data from other programs for use in estimating costs. Please call me at 415/957-3330 if you have any additional questions or if you would like us to undertake any additional analysis.

Sincerely,

Sandi Hunt

Sandi Hunt



Ms. Lynn Davison
King County Mental Health Division
506 Second Avenue
512 Smith Tower
Seattle, Washington 98104

May 30, 1994

Dear Lynn,

It has been my pleasure to review the work done to date as you develop into a prepaid health plan. I am very pleased to see King County move in this direction in anticipation of the emerging State and National health reform. I believe your efforts will be rewarded. As county government develops more expertise in behaving like an insurance company, and as your provider community develops more expertise in at-risk contracting I believe both consumers and taxpayers will receive more value. Being "ahead of the game" should be a real asset.

You are to be congratulated on the volume and scope of work done. Your package to me was most impressive and as we spoke it was obvious there was more to share. I hope your team is feeling some sense of pride in your growing expertise.

The areas of your concern were clear in your letter and our talk. I will attend to them in order. Then I will follow with some observations and references. A large part of the value of utilizing folks like me, in addition to minimizing risk and mistakes, is in developing your network with others who have managed similar ventures. Please be aware that after sending you this communiqué I will be putting together a "CARE" package for you that I hope will be of some use.

Financial Assumptions

Because the initial prepaid health plan excludes inpatient care the risks involved are automatically lessened significantly. Again it is good that the county is moving in this direction for it will enable you to step into the world of risk-based care purchasing more gently. In understanding the risk and financial flow there are only a few variables to put together.

- Historical funding strategies. The manner in which providers historically received funding largely shapes the impact of a shift to risk-based contracting. Medicaid has been funded as a fee for service program, therefore services that were more profitable were more present. Public (DMH) funded services were more often funded in a grant in aid manner and therefore demand may be artificially deflated. Put the two together and we can expect certain changes. The Medicaid program is "mature" and demand is largely satisfied. The "public" program may have greater expansion. However, based on the past we may expect that expansion to largely be lesser impaired individuals whose care would be less costly. Given that the largest funding per consumer was in the Medicaid program, then the shift to risk-based contracting should leave room for expansion to cover some significant growth in demand.
- Provider payment system. Just like the way we historically paid providers shaped our current situation the way we intend to reimburse providers will shape the financial demands in the future. Moving to an episode rate payment system will result in significant changes in trends of care received by consumers. Based on the experience of other similar programs we would experience an increase in case management activities, skill building and therapy groups and home-based or intensive outpatient

services with more aggressive monitoring of the need for medical intervention. The overall episode lengths for tiers one and two will probably reduce.

- Clarity of covered lives. Knowing the total eligibles allows for more accurate prediction of utilization. Sounds like a statement of the obvious, but it is not with historical program funding such as occurred with the DMH dollars. It is in the PHP's best interest to try to define more tightly who is eligible for care so that epidemiological surveys can be done. Your definition is good and pragmatic but in the long run agreements with the state and between PHPs will help share the risk and define the limits i.e. care to transients, what is catastrophic coverage, upper income limits related to need, etc.
- Clarity of covered benefits. What are the parameters of what will be reimbursed? You have done a good job of defining the expectations that encourage the provider to be creative in meeting the needs of people. The provider has the risk and therefore the incentive to be cost effective. Your responsibility in this type of system is to aggressively work to remove unnecessary bureaucratic barriers that have been imposed over the past. If they take the risk you need to help make sure they have room to be creative in meeting needs.
- Reserves. The greater the confidence in the accuracy of the data and the ability to predict the future the less risk reserves are needed. Extreme variation creates risk. By only having outpatient in the plan the volume and size of extreme claims are lessened. Your reserve assumptions are sound and appropriately conservative in the absence of good historical data. The new payment system will change the expense flow, but the new MIS will monitor. To the extent your MIS is timely and accurate and your contracts reflect the reality of finite limits for non-Medicaid consumers your assumptions look very workable. I would encourage you to contemplate in your operating plan a policy based calendar for independent actuarials in the future. The patterns of care will change, demand will change and you want the least intrusive and costly manner with which to determine rates. Actuarial samples at predetermined times, say in two years and then every three or four years after that, may be an excellent way to cost efficiently update the rate and risk issues of the plan.
  The logic behind your rate and service package expectations looks solid. The concept of converting all costs down to a single time unit rate provides a unit of comparison for the plan and providers. Your rate-$63- looks reflective of many current surveys. State Medicaid plans, the Group Health Insurance Association of America and Psychotherapy Finances survey all would support the rates reasonableness. As you note changing practice patterns you may want to consider a time benchmark under one hour- one-quarter or one-half hour units will be more reflective of the most common care units. The service package length of stays you have set look generous and therefore should help minimize risk to both you and the provider community. I would expect your actual experience in tiers one and two to decrease significantly and you may want to build in some kind of planned reduction to signal that expectation i.e. reflect a 10% reduced length of stay base rate in year two.
- Benefit coordination. Are other coverage plans changing and effecting this plan? Are there incentives or disincentives for the same or similar services to be paid by other sources? As the State implements a primary care case management model in primary health care some impact may be felt in your plan. People will migrate. Per our conversation this is clearly an issue you see and the answer largely lies in building effective relationships with the medical care networks that will emerge.

In reviewing your data presented the following information emerges: The amount allowed per case seen is quite generous, that is the historical dollars available along with the anticipated utilization still give an amount per case higher than most public or Medicaid pools per case for similar populations in other areas. The expectations of visits per case used in your tier structure are generous, and if providers have flexibility in service delivery and risk-based contracts should pose few problems. Parenthetically, I agree with your strategy of using medians for the basis of establishing your tier pools. The functional level definitions and historical process regulatory oversight create a system where averages would reflect little reality, while medians tend to reflect patterns of cost or practice.

One caveat emerges, because we don't have the ability to identify the total size of the eligible pool of potential recipients we can not do some comparisons of the most common way data is presented in managed care- the per member per month costs.

At the point where you can make those comparisons I would encourage you to compare your numbers with; the Health Care Financing Administration, the American Managed Behavioral Healthcare Association, or the American Academy of Actuaries.

Risk Reserves

It is clearly the intent of the prepaid health plan that the administrator of the plan is to be at-risk in meeting the contractual agreements. This requires that the major tasks of the administrator are risk management and relationship management. How many people are eligible for what benefits? How many will avail themselves to receive the care? What can we purchase it for? Where can we purchase that offers us the most cost-effectiveness that satisfies consumers? The activities are similar to the tasks of the RSN, but there is a significant paradigm change. The RSN delivered some care, coordinated care, and purchased some care. The PHP acts like an insurance company. Timely, accurate information, money management and purchasing savvy are the most critical skills.

How much money must be set aside largely depends on your "outlier" risk pool, your use of reinsurance, and the payment methodology with providers. Your concept of two risk pools- an anticipated fund and a reserve is very prudent and reflects the most common methodology utilized in self funded insurance programs. The amounts you plan to set aside look appropriate, but the issue of uncertainty here is the absence of an "outlier" database. Building such a database and ongoing report in your MIS system needs to be a priority in your planning.

Your assumptions look fiscally conservative and prudent, contingent on risk-sharing contracts with your providers.

Outcomes and Indicators

The PHP must answer to three groups; the taxpayers- in the form of their elected officials, the oversight regulatory executive branch agencies, and the consumers and families who utilize the purchased care. Keeping these audiences in mind can help focus the outcome system.

Consumers are concerned about accessibility and acceptability of services. How promptly did they get in? How convenient were the services? Would they use them again? Would they recommend others use them? Were they treated respectfully?

Taxpayers want to know if the services purchased worked. Is the individual consuming less tax money or contributing more tax money to the system? Were we able to purchase a bargain? Given that we a purchasing in "bulk", i.e. buying a lot of care from a limited vendor pool we should be able to negotiate some good rates- buy "wholesale". How much discount did we achieve compared to what anyone could buy of the street?

The executive branch regulatory groups will have their own unique demands. You must satisfy them- they are a customer of yours. You also want to negotiate with them- their answers in return for bureaucratic relief. A major part of the paradigm shift is your need to try to simplify the process regulatory environment that was set up to be an intentional barrier to care. In risk-based contracts you want to maximize your freedom to negotiate in exchange for taking on the risk.

In looking at your plan I would encourage a more formal plan to take away noxious bureaucracy both at the state level and at the county level. You need to prioritize what is important and only count or monitor that, as much energy needs to go into eliminating historical requirements that are unnecessary and developing a system that overcomes the impulse to impose "good intentions" that emerge in the future and would cloud the focus of what is truly important and cripple your provider community. System simplification needs to be a goal. Your provider community can not be successful if the processes they must navigate are over regulated.

Medical Necessity

Health care benefit plans require a policy driven basis for eligibility to utilize the benefits. All plans evolve criteria for when individuals can access care, how much, and the process for resolving conflicts. Your operational definitions of the tiers and your case mix assumptions both looked very solid to me. In considering the role of the tiers we must bare in mind that they are only useful as a construct for care eligibility or reimbursement. Their test is how well they assist in either task for which they are needed. In reviewing your staffing model I saw an assumption that warrants a comment. Most insurance companies and hospitals hire medical consultants part time for policy oversight for specific populations i. e. a children's medical director, an adult medical director etc. Each population of concern having a resource for overview of written policy, not case consultation. You must consider treating your revenues for clinical input into the development of the benefit plan and the resolution of conflicts in light of the tasks. Securing the resources of several individuals with administrative (insurance?) medical or psychological backgrounds to help develop and update the plan as experience shapes it may be more worthwhile than building a more intensive relationship with a more general practitioner. The responsibility for clinical decisions and care coordination should reside in the network you purchase, not at the PHP. Several specialty firms have evolved to give plans and providers specific expertise as needed. One such model I mentioned to you is Peer Review Analysis of Boston Ma. (617-375-7700, Al Lewis, president).

Implementation Plan

The task of putting a small insurance company together is quite complex. When I received the packet one of my first acts was to seek out the implementation plan as it is crucial for success. I was pleased to see yours and the work that has gone into it. I would encourage you to identify the most important policy issues and build them into the plan. Any essential piece that requires multiple group approval, unique technical expertise or equipment or significant financial outlay must be on the plan.

I believe you have a major decision about partnering with either a managed care firm or an MIS firm. In government, largely because of the realities of limitations in personnel the probability of you smoothly pulling up the total package internally seems unnecessarily burdensome. Governments tend to be good at purchasing not so good a hiring large numbers of talented folks on tight schedules. Managed care organizations and MIS companies already exist that can deliver a product on time with quality to your specifications. I believe it would be prudent to consider one role or the other for external vending.

At the point you are I would also recommend you seek some assistance in organizational development. The organization chart you attached does not seem consistent with your intended purpose. Establishing some focused priorities, clarifying the role of the PHP and the RSN, establishing the expectations and then setting up the working roles and relationships between people. I would encourage you to look at small insurance or managed care staff models. How many people do you need of what expertise? Should you separate the RSN from the PHP at every point below the manager. The purposes and priorities of the current two tasks are quite different and you want to develop different frames of reference, career tracks and internal performance expectations to reflect those differences. I would wonder if you might not want to consider the services provided by the RSN as being evaluated on the same provider profile mechanism as the other providers services i.e. holding the RSN equally accountable to the performance expectations as any other provider?

MIS

The management information system will be a very major piece of the overall success or failure of the new system. The system components listed on your plan look excellent. The whole section is very thoughtful and professional. Two drivers need to be visible in the successful plan; cost-effectiveness and enhanced independence of the users. To build the successful system you clearly must know the desired outcomes to set the fields to measure them. You must want to have the most cost-effective eligibility determination system and provider payment system. You must spec your total system adequately to maximize the

The bureaucracy inside the PHP likewise needs to reflect an outcome orientation and must take pains to cast off as much of the historical process regulatory orientation as is possible. Government is known for control and copious layers of oversight. The challenge is to focus on a handful of priorities and hold individuals accountable for results. If government is going to be an insurance company then it surely must take some lessons from Reinventing Government or embrace the concepts behind total quality management. The MIS system must be done right, automation is important, your people must be exposed to experts and therefore training and consulting dollars must be spent, individual accountability must occur and that requires the support systems- fiscal, personnel and purchasing must either be held accountable to timely accurate responses on the same priority basis or they must make policy level guidelines and get out of the way.

I would advocate that you consider developing a sampling based outcome system. The concept of provider report cards or provider profiling seems to offer great promise as a cost effective means of monitoring performance in purchasing services. The managed care firms routinely sample two to five per cent of consumers. The use of such an approach focusing on a handful of questions about access to care, acceptability of care received, the impact of the care and the comparable cost of the care would answer an awful lot about the system.

You are establishing a system in which the pressure for care coordination has been shifted to the provider. To the extent possible your primary function is establishing and maintaining the benefit plan and an acceptable provider network to deliver the benefits. Your outcome needs to focus on finding the right benefit package- for consumers and taxpayers, and finding the right providers-accessible, satisfying and cost-effective. Minimize your role in utilization management- the providers should have the responsibility to work together. Minimize your role in determining good practice- the outcomes along with defining a minimum administrative capacity can define their competence to practice (i.e. all provider networks must be accredited by a reputable body such as C.A.R.F. or J.C.A.H.O.). Minimize your role in training- they have the burden of offering a standard of care worthy of inclusion in the network and they have the need to maintain their skills. You are in a transition and while you can't eliminate the dependency which was created overnight you need to set the expectations of the various groups roles now and move aggressively toward those ends.

Case Management Methodology

Per our discussion I apparently did not receive the material that discussed case management in detail. Material received detailed the state hospital liaison role and crisis role of the RSN. From our discussion I would encourage you to think through the care coordination role. The case management model gaining popularity in public managed care is the case manager as broker, behaving in much the same manner as the primary care case manager (general practitioner) in Health Maintenance Organizations. For smooth delivery of care you want a minimum number of transfers, the ability of a single person to guide the person through the system and the ability of that case manager to make wise financial decisions on behalf of the taxpayer. I like the model that makes identified lead agencies responsible for the coordination of care. Those agencies can be identified to the public by a common logo representing the public benefit plan, and by having risk-based contracts they have an incentive for a smooth care system. As long as their performance is monitored you have as simple a system with the incentives as close to the "front line" as possible. The utilization of a total quality management approach in conceptualizing case management will lead you to the fewest transfers and a system where the front line consumer contact person has the greatest latitude (and responsibility) for care coordination. Give the consumers choices among providers to start care with, sample consumers for feedback and clarify the provider responsibility for delivering or purchasing all of the care for a given population. The system will change for the better when the consumers have a choice of provider networks and a voice in provider retention in the networks.

automated systems ability to sample outcomes and audit transactions. I would hope that the system that develops maximizes the providers attention to be successful in seeking other revenues i.e. looks as much like traditional insurance as possible so that they will improve their insurance collections. Additionally I would hope that if you don't use a managed care organization you will compare the possibilities of using a vendor for your claims processing (and the related reports). It would be time well spent at this point to start building public policy and management report formats that would help determine the information fields really needed.

Provider Training

In any period of rapid change training is of great significance. Managed care is moving at a rapid pace and there is a need for both the purchasers and the providers to know as much as is possible about the possibilities. Likewise, not inconsequential, both purchaser and provider are being called upon to make a major paradigm shift in the way they conduct themselves with each other. There is no doubt- training should occur. I hope your staff can avail themselves of training such as put on by the Institute for Behavioral Health, the National Managed Care Congress, Infoline and Centralink. You need a few people who know the industry.

As far as provider training goes- they definitely need it as well. The issue becomes who is responsible and who chooses the agenda? I would advocate that you want them to be as much in control of their agenda as possible. Just because of the rapidity of change you may want to give them some money for training, but I would encourage letting them organize and secure the training themselves. Foster their interdependence with each other, not their dependence on you.

U. S. Behavioral Health

USBH has an excellent reputation in the field. Two of it's senior people have significant public mental health histories. The company has not done much public oversight. They have very good eligibility, network development, utilization management, claims resolution and monitoring report systems. The possibility of your exploring King County having the role of establishing the benefit plan parameters, the monitoring report parameters and USBH administering the system would likely be a fruitful path to explore. The task of determining which roles USBH or any other companies might play requires determining how you would demand they report to you i.e. you must determine what you need to receive from them in the greatest detail practical. Once that is done you can compare their approach, cost and reputation and determine whether you can do it quicker, better or cheaper. I would encourage you to challenge them to respond to the largest role possible and scale the specific tasks away from them on the "quicker, better, cheaper" scale. You want to steward the public funds to purchase the greatest benefit for the largest number of people possible. Pick and choose the operational roles you want to "own" carefully, it is easier to change what you "rent".

I will package some reference material that may be of assistance to you and send along with the original copy of this document. It has been a pleasure to speak with you and see the quality work your team has accomplished. If I can assist in any further way please be aware that I would be happy to lend my resources to you. Wishing you a great venture.

Sincerely

Robert L. Dyer Ph. D.