National Evaluation of Medicaid Demonstration: Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities

Year 2 - Implementation Status Report

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Community-Based Alternatives to Psychiatric Residential Treatment Facilities

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Section I. Background and Introduction

This report provides an overview of the status of the Medicaid Community-based Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant Program that is currently being implemented in nine States. The structure of the report is as follows: Section I provides the background information on the Demonstration grant waiver program as well as its evaluation. Section II provides four cross State comparison tables and describes successes, barriers to success, and lessons learned by the nine States during the planning and initial implementation of their Demonstration grant waiver programs. The Appendix provides an overview of the approved Demonstration grant waiver program plans for each of the nine States.

Background

The New Freedom Commission on Mental Health (the Commission), created on April 29, 2002, was charged with making recommendations to the President that would enable adults with serious mental illnesses and children and youth with serious emotional disturbances to live, work, learn, and participate fully in their communities.

On July 26, 2003, the Commission released its final report, *Achieving the Promise: Transforming Mental HealthCare in America.* The final report outlined significant barriers associated with providing community-based services for children and youth with serious emotional disturbances as an alternative to placing them in Psychiatric Residential Treatment Facilities (PRTFs). Children, youth, and families typically have little influence over decisions affecting service delivery, planning, and the use of financing to deliver care. When comprehensive community-based options are unavailable children and youth are often incarcerated in the juvenile justice system.

To remedy this problem, the Commission recommended that the Centers for Medicare & Medicaid Services (CMS) conduct a Medicaid waiver Demonstration project that would enable States to provide community-based services as an alternative to psychiatric residential treatment for children and youth with serious emotional disturbances. Through this Demonstration grant waiver program CMS is developing reliable cost and utilization data to evaluate effective community-based models such as systems of care and wraparound services that can reduce placement in institutional settings.

Over the last decade, PRTFs have become a primary Medicaid supported treatment setting for children and youth with serious emotional disturbances requiring an institutional level of care. However, PRTFs were not included as one of the types of institutional settings eligible for the Medicaid 1915(c) waiver authority to provide home and community-based care as an alternative to institutional care. Before this Demonstration grant waiver program, the 1915(c) waiver authority was only to provide alternatives to institutional care in hospitals, nursing facilities or intermediate care facilities for the mentally retarded. Many States and advocates have long hoped to extend the home and community based services waiver authority to children and youth eligible for PRTF level of care, so children and youth could stay with their families and receive services in their home communities.

On June 22, 2009, to mark the 10th anniversary of the Supreme Court Olmstead v. L.C. Decision, President Obama announced the "Year of Community Living" initiative. The President reinforced his vigorous commitment to enforcement of civil rights for Americans with disabilities and to ensuring the fullest inclusion of all people in the life of our Nation. This action underscored the importance of the Olmstead decision and affirmed the Administration's commitment to addressing isolation and discrimination against people with disabilities that still exists today.

The Olmstead decision, issued in July 1999, requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." This decision interpreted Title II of the Americans with Disabilities Act (ADA), which gives civil rights and protections to individuals with disabilities and guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

Legislative History of the Demonstration Grant Waiver Program

The competitive Medicaid Demonstration grant waiver program for Community-based Alternatives to PRTFs was created by section 6063 of the Deficit Reduction Act of 2005 (P.L. 109-171). The Demonstration grant waiver program allows up to 10 States (as defined for purposes of title XIX of the Social Security Act) to compare the cost effectiveness of providing care for home and community based services with care in PRTFs for children enrolled in the Medicaid grant program.

The purpose of the Demonstration, according to the Deficit Reduction Act of 2005, is to:

- test the effectiveness of the program in improving or maintaining a child's functional level;
- test the cost effectiveness of providing coverage of home and community based service alternatives to psychiatric residential treatment for children enrolled in the Medicaid program under of title XIX of the Social Security Act, as they compare to the cost of care in a residential program; and
- maintain budget neutrality (1915c cost neutrality) so that aggregate payments under the Demonstration do not exceed the costs estimated to have been incurred had the Demonstration not been in place.

For purposes of the Demonstration, PRTFs were deemed to be facilities specified in section 1915(c) of the Social Security Act (in addition to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded). The Demonstration grant waiver program targeted children and youth who were not otherwise eligible for any Medicaid-funded, community-based services or supports. At the conclusion of the Demonstration grant waiver programs, States have the option of continuing to provide home and community-based alternatives to PRTFs for participants in the Demonstration under a 1915(c) waiver, as modified by the provisions of this Demonstration.

CMS anticipated awarding each state applicant between $15 and $50 million over the grant period of the Demonstration project. CMS reviewed and approved each State's Implementation Plan (1915c waiver application) before allowing States to access funds for Federal reimbursement of services under this grant. Section 6063 also provided an additional $1 million for a National Demonstration Evaluation.

Grant Awards

CMS awarded PRTF Demonstration Grants to ten States: Alaska, Florida, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina and Virginia. States receiving an award were required to develop and submit a full Section 1915(c) Home and Community-Based Services Waiver application, using the same template that CMS used for all other such waivers. Participating States are required to provide state matching funds. Florida's legislature did not approve State matching funds. In 2009, Florida officially rescinded their grant application and is no longer participating in the Demonstration grant waiver program. The remaining 9 States have approved 1915(c) PRTF

waivers. States receiving grants estimated that potentially 10,000 children with serious emotional disturbances will benefit from the new programs funded by these grants.

Services

Grantee States recognize the wraparound approach as an ideal model to serve children and youth in the community. All nine States have included some form of wraparound approach in their waiver application. Wraparound is a team-based approach to provide community based mental health and medical services to youth and children with serious emotional disturbances. The team usually includes the youth, family members, care coordinators, and service providers. Together the team and with the child and family formulates an individualized plan of care that allows the youth to receive supports and services in the community rather than in a PRTF. The team, child and family work together to ensure that the person-centered plan is implemented.

Frequently cited community services being furnished under the Demonstration grant waiver program include respite care, family services, and employment related services. Respite care includes services designed to give a hiatus to the primary caregiver while meeting the safety and daily care needs, either inside or outside the home, of the youth with serious emotional disturbances. Family services being offered by the States are primarily focused on better informing caregivers on how to support their child, such as providing them with information on their child's mental health diagnoses, medication management, behavior management, systems navigation, financial management, and evidence based practices. Employment related services offered by States center on preparing youth and providing them with the necessary tools to succeed in the workplace, such as job skill development, transportation to and from the job, and assistance with job searching.

Other popular services being offered by the States included customized goods and services, consultative clinical and therapeutic services, skills training, and transition services. The services States are offering are similar to one another, but there are some differences. For example, Alaska has been providing treatment and intervention mentor services. A Training and Intervention Mentor (TIM) is assigned to monitor and implement the youth's integrated services plan day-to-day services. The TIM is actively involved with the family and youth to ensure that treatment and services are provided and followed as described in the service plan that he/she helped the family develop. These services are similar to the Community Guides offered by Georgia and Companion services that Virginia is offering.

States are also offering some unique services. Maryland is providing expressive and experiential behavioral services. These services are a group of techniques that are expressive and creative in nature. The goal is to help participants find a form of expression beyond words or traditional therapy. Some of specific types of services included are Theraputic Art, Dance/Movement and Music Services.

Specific details on the services each State is providing can be found in the Appendix.

Evaluation

CMS is conducting an evaluation of the Demonstration grant waiver program and will produce interim and final reports. The evaluation will include analyses of data obtained from States participating in the Demonstration grant waiver program. CMS is collecting and will analyze individual-level information as well as aggregate financial data from participating States.

The overall evaluation directly addresses the two primary questions posed in the statute. Does the provision of home and community-based services to children and youth under this Demonstration: (1) result in maintaining or improving a child's functional status; and (2) on average, cost no more than anticipated aggregate PRTF expenditures in the absence of the Demonstration?

IMPAQ International and Westat, contractors selected to conduct the national evaluation, have worked with CMS and State grantees to determine a final minimum data set (MDS). The MDS allows access to individually identifiable functional assessment data for project specific analyses and project-to-project comparisons whenever possible. State grantees acquired approved functional outcomes across the following life domains: community living, school functioning, juvenile justice involvement, family functioning, alcohol and other drug use, mental health diagnoses, program satisfaction, and demographic variables. States used one of three approved functional assessment instruments, Child & Adolescent Functional Assessment Scale (CAFAS), Child and Adolescent Needs and Strengths (CANS), or Child Behavior Checklist (CBCL), to gather these data from clients at baseline, six month intervals during Demonstration participation, and at discharge from Demonstration services. In addition to the functional outcome data elements, the MDS designed by the National Evaluation includes demographic information, mental health and health care history, environment variables, program fidelity measures and services data. States are required to submit MDS files to CMS on a semi-annual basis throughout the project.

States also provide aggregated financial information about the costs associated with provision of Demonstration services. IMPAQ and Westat worked with CMS to access and utilize aggregate financial data submitted by States to assess the cost effectiveness of the Demonstration grant waiver program.

Section II. Cross State Implementation Status Summary

Section II provides summary tables to facilitate cross-state comparison of the current status of waiver programs. Table 1 includes the dates State waivers and any amendments were approved, as well as the geographic reach. Table 2 provides an overview of client enrollment. Planned versus actual length of stay can be compared in Table 3. Table 4 provides a recap of what Medicaid provisions were waived. A narrative section follows the tables, which presents illustrative successes and challenges in the States' implementation of the waiver programs.

Current Status of State Demonstration Grant Waiver Programs Table

On October 1, 2007, Alaska, Mississippi, and Montana were the first States to have their Demonstration grant waivers approved. They were closely followed by Indiana and Virginia later in the month. In November 2007, Mississippi became the first State to enroll a participant into the Demonstration grant waiver program. Since November 2007, all States have enrolled children and youth into their programs, with Maryland being the final State to enroll a participant in September 2009. The number of children and youth enrolled in the Demonstration grant waiver program varies by State. As of September 30, 2009, Alaska and Maryland each had 3 youth enrolled, while Indiana had 406 participants and Mississippi had 349 participants. The variance in enrolled participants was due to a variety of factors, including the population being served and length of program operation. For example, Alaska focuses on children and youth diagnosed with fetal alcohol spectrum disorder. Since this diagnosis affects only a small part of the overall population, the expectation is that Alaska will serve a smaller group of children and youth than the rest of the participating States. In September 2009, Maryland began serving youth and had a small number of participants enrolled, as compared to Mississippi and Indiana, both of which have been serving youth for over a year and have a large group of participants. Maryland expects to rapidly increase enrollment in year 3 of the Demonstration grant waiver program.

In the Federal fiscal year beginning October 1, 2008, and ending September 30, 2009, participation in the Demonstration grant waiver program grew from 253 children and youth to 978 children and youth. Among the enrolled participants were 358 females and 620 males. Most Demonstration participants (715) were diverted from PRTFs, while the remaining 267 were transferred out of

PRTFs.[1] A majority (668) of the enrollees were between the ages of 13-18 years. Only 16 youths between the ages of 19-21 years have been in enrolled in the Demonstration grant waiver program. A total of 394 participants were discharged from the Demonstration grant waiver program.

Table 4 describes the provisions waived by the States through the Demonstration grant waiver program. If desired, the waiver program enables States to provide services in focused or targeted areas of the State where the need is the greatest or where providers might be located, rather than offering the services statewide. Georgia, Indiana, Maryland, and Montana all waived *statewideness*. Another attribute of the waiver was that it allowed States to specifically serve children and youth at risk of institutionalization without being required to make waiver services available to the Medicaid population at large. All States, with the exception of Kansas, chose to waive *comparability of services*. Finally, the waiver also allowed States to provide Medicaid to children and youth who would otherwise be eligible only in an institutional setting, due to the income resources of spouse or parent. Alaska, Kansas, and South Carolina waived *income and resource requirements*.

Tables 1-4 provide additional details.

[1] Please observe that the total number of diverted and transferred children and youth do not sum to the total enrolled in Demonstration waiver. Kansas notes that some of their enrollees have been both diverted from PRTFs and transferred out of them, therefore resulting in a higher count.

Table 1. Dates of Demonstration Grant Waiver Approval Process and Geographic Reach[1]

	ALASKA	GEORGIA	INDIANA	KANSAS	MARYLAND	MISSISSIPPI	MONTANA	SOUTH CAROLINA	VIRGINIA
Demonstration Grant Waiver Approval Process									
Approval Date	10/01/07	08/07/08	10/04/07	01/01/08	12/27/07	10/1/07	10/01/07	12/20/06	10/31/07
Amendment Approval Date	N/A	N/A	N/A	N/A	03/01/09	12/20/07 6/24/09	9/01/09	N/A	N/A
Proposed Effective Date	10/01/07	09/01/08	10/1/07	04/01/08	01/01/08 3/1/09 (amend)	11/01/07 4/1/09	10/01/07	01/01/08	12/01/07
Approved Effective Date	10/01/07	09/01/08	10/1/07	04/01/08	01/01/08 3/1/09 (amend)	12/20/07 4/1/09 (amend)	10/02/07	01/01/08	12/01/07
Geographic Reach – Number of Regions/Localities/Counties Participating									
Number planned to participate by end of waiver	88 counties	Statewide	Statewide	Statewide	Statewide	Statewide	5 regions	46 counties	100 counties
Number actually participating September 30, 2009	3 counties	27 of 159 counties	40 of 92 counties	Statewide	4 of 24 counties	Statewide	1 of 56 counties	13 counties	23 counties

[1] Source: Data collected for CMS reporting purposes by National Evaluation Technical Liaisons and verified by grantee states.

Table 2. Client Count and Demographics[1]

	ALASKA	GEORGIA	INDIANA	KANSAS	MARYLAND	MISSISSIPPI	MONTANA	SOUTH CAROLINA	VIRGINIA	Total
Client Enrollment										
Date of First Client Enrollment	3/10/09	8/03/09	2/05/08	4/1/08	09/15/09	11/28/2007	04/29/08	6/11/2008	3/14/08	N/A
Number of actual enrollees as of September 30, 2009 (unduplicated counts)	3	9	406	150	3	349	13	15	30	978
Number of transfers from PRTFs to date	2	5	20	111	0	91	7	1	30	267
Number of diversions to date	1	4	386	43	3	258	6	14	0	715
Number of discharges to date	0	0	139	67	0	171	7	4	6	394
Number of re-enrolled to date	0	0	14	0	0	2	0	0	0	16
Number of females	1	5	120	67	1	141	7	3	13	358
Number of males	2	4	286	83	2	208	6	12	17	620
Age 12 & under	0	4	149	17	0	106	7	6	5	294
Age 13-18	3	5	255	122	3	241	6	9	24	668
Age 19-21	0	0	2	11	0	2	N/A	0	1	16

[1] Source: Data collected for CMS reporting purposes by National Evaluation Technical Liaisons and verified by grantee states.

Table 3. Planned vs. Actual Participant Length of Stay[1]

	ALASKA	GEORGIA	INDIANA	KANSAS	MARYLAND	MISSISSIPPI	MONTANA	SOUTH CAROLINA	VIRGINIA
Planned Average LOS per waiver (days)	244	241	164	270	310	270	253	365	197
Actual Average LOS as of September 30, 2009 (days)	139	Insufficient Data	Insufficient Data	178	Insufficient Data	199	180	276.7	188

[1] Source: Data collected for CMS reporting purposes by National Evaluation Technical Liaisons and verified by grantee states.

Table 4. Waived Provisions[1]

	ALASKA	GEORGIA	INDIANA	KANSAS	MARYLAND	MISSISSIPPI	MONTANA	SOUTH CAROLINA	VIRGINIA
What is waived?									
Comparability	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
State wideness	No	Yes	Yes	No	Yes	No	Yes	No	No
Income and Resource Rules	Yes	N/A	No	Yes	No	No	No	Yes	No

[1] Source: Data collected for CMS reporting purposes by National Evaluation Technical Liaisons and verified by grantee states.

Narrative Summary of Successes, Barriers, and Lessons Learned

As the Demonstration grant waiver program enters its third year, all nine States are currently enrolling children and youth. Although the States continue to report implementation challenges, they have identified meaningful successes and lessons learned. The summary below describes the States' implementation of services and outlines the major challenges, achievements, and lessons learned during the program's second year.

- **All States have successfully transitioned from planning to implementation.** All nine States have begun enrolling participants in the Demonstration grant waiver program. Some States, such as Indiana, Kansas, Mississippi, Montana, South Carolina, and Virginia, have more than a full year of experience delivering services through the Demonstration grant waiver. Other States, such as Alaska, Georgia, and Maryland, have faced significant barriers and delays in implementing their programs. As the second year came to a close, all participating States were successful in getting their programs operational and began participant enrollment.

  Alaska's major program implementation barrier was their State regulations. Although the program was ready to enroll youth, the State regulations did not correspond with the population targeted for services. The Demonstration grant waiver was written to serve youth 14-21 years of age. After implementing the Demonstration grant waiver program, the State identified a number of youth under 14 years who met level of care criteria but could not be served through the Demonstration grant waiver. Another identified problem was the service rates Alaska offered through the Demonstration grant waiver. The rates offered through the Demonstration grant waiver program were not competitive with other mental health service payments being offered outside the waiver. Agencies balked at providing services at lower reimbursement levels than comparable fee-for-service mental health services. Alaska realized changes to State regulations were necessary to make the Demonstration grant waiver more effective. Recently, new regulations were adopted that broadened the age range of the population served from 14-21 years to ages 0-21 years. The new regulations also removed arbitrary unit limits and increased payments to comparable mental health service payments. Alaska believes that with the recent changes to State regulations they will be able to better serve all children and youth meeting waiver admission criteria.

  Several significant system changes delayed Georgia's implementation of their Demonstration grant waiver. Georgia's Medicaid agency, the Department of Community Health (DCH), switched claims vendors during the Demonstration grant waiver's implementation stage and decided not to accept any changes to their claims processing system for a year. DCH's decision not to allow changes to the system affected their process to collect claims data related to the Demonstration grant waiver. As a temporary fix, DCH and the former Division of Mental Health (DMH) decided to set up a separate claims system solely for the Demonstration grant waiver. DCH was reluctant to set up a permanent and separate claims processing system for the waiver

program because at the end of the Demonstration period they do not want to switch all the providers to the main claims processing system. They hope that at the end of the Demonstration period all vendors would have submitted claims through this database which would eliminate the need for a fiscal intermediary and allow for direct billing to the new Medicaid system.

Georgia also recently restructured their Department of Human Resources, which was the department responsible for administering the Demonstration grant waiver. On July 1, 2009, the mental health and substance abuse departments became a separate behavioral health agency known as the Department of Behavioral Health and Developmental Disabilities (DBHDD). This reorganization caused the umbrella agency to change, and required new leadership and new inter-agency agreements for the program. Georgia was able to overcome all of these obstacles and enroll their first participant in August 2009.

Maryland's challenges to implementing the Demonstration grant waiver relate to the necessary alignment of multiple processes. Before youth could be enrolled, Maryland had to ensure that the information systems were fully automated; regulations promulgated; and providers enrolled. Maryland's waiver established that youth cannot be enrolled until a caregiver, peer-to-peer support provider, a respite provider, and a crisis and stabilization provider were available in their jurisdiction.

During the implementation phase, Maryland's Governor's Office issued a Request for Proposals (RFP) for Regional Care Management Entities (CME). This RFP allowed Maryland to offer the Demonstration grant waiver to youth in all of its 24 jurisdictions. As a result of the awards, there was a transition from some existing CMEs to multiple and/or different CMEs in some jurisdictions. The State also issued a RFP for the Administrative Service Organization (ASO), which resulted in a transition from an existing vendor to a new vendor. Both of these transition processes required the Demonstration waiver grantee to create a modified implementation plan for a period of approximately six months to ensure no violation of State Procurement Statutes or Regulations occurred. The modified plan was executed without any significant issues, but delayed enrollment of youth in the waiver.

The delays encountered by Alaska, Georgia, and Maryland, were similar to implementation challenges experienced previously by other Demonstration States. Many of the States had to spend time and money building their database and management information systems, developing implementation plans, and amending their waiver or changing State regulations to better serve their children and youth.

- **States are providing a similar array of home- and community-based services.** States are offering many similar alternatives to psychiatric residential treatment. The four most commonly provided services are respite, wraparound, family training or supports, and employment services.

  All nine States offer respite services. Across all States, the services provided are short-term, offered both inside the home and in community settings, reimbursed at an hourly or daily rate, and accessed in routine or crisis situations. The only notable difference

among the States is that Mississippi allows respite to take place in PRTFs for up to 29 days, while Montana explicitly prohibits the provision of respite in PRTFs.

Eight States explicitly reported offering wraparound-based care through the Demonstration grant waiver program. The States tailored their wraparound services to the child's needs while stabilizing, maintaining, and strengthening the child's level of functioning. Examples of wraparound services States offer include mental health, social, educational, vocational, and recreational services. Indiana, Kansas, Montana, and Virginia specifically noted providing wraparound facilitation as a means of ensuring the implementation of the wraparound plan of care by participants. The States offering wraparound facilitation employ a wraparound facilitator. Some of the facilitator's duties may include completing the participant's assessment, developing a plan of care, forming a wraparound team, and tracking and monitoring the child's progress.

Seven States offer some form of family training or support; the exceptions are Mississippi and South Carolina. The States that provide family training to parents, unpaid caregivers, or the youth themselves, cover key topics such as mental illness diagnoses, medication management, financial management, and social skills. Montana hired family support specialists to provide assistance to the in-home therapist in addition to teaching parents or caregivers about the child's mental illness, behavior management plans, and parenting techniques.

Alaska, Georgia, Kansas and South Carolina offer employment services through the Demonstration grant waiver program. The supported employment services offered by Alaska, Georgia, and Kansas focus on helping youth identify the type of job that interests them and develop skills to acquire and maintain such a job. Specific supported employment services offered by these States include assessment of the participant's employment stability, job skills refresher training, regular worksite observation and feedback, and transportation to and from work. South Carolina is taking a more general approach to preparing the participant for paid or unpaid employment by teaching participants basic concepts like adherence, attendance, task completion, problem solving, improving attention span, and safety.

- **The services in highest demand vary by State.** No one service was most frequently used across the States. Several States have seen a high demand for respite and wraparound care. For other States, frequently used services included habilitation services, case management, peer-to-peer support, family support specialists, mental health counseling, and mentoring.

  For the most part, States have not identified a need to develop new services to better serve their population. In the program's second year, only Montana decided to add additional services based on family, youth, and provider feedback from the previous year.

- **Most States successfully increased their enrollment of participants; however, retaining participants was a challenge for some.** Most States have charted gains in their recruitment of participants over the past year. Marketing campaigns and community outreach are two recruitment strategies that States were finding particularly

helpful. A few States attributed their success to pre-existing partnerships with various providers including PRTFs. Montana noted that their relationship with PRTFs has grown stronger and that they were working more as partners. The PRTFs and State were successfully working together to enable youth to make a smooth transition to the waiver program. When youth leave the Demonstration grant waiver program and return to a PRTF, the Montana Plan Manager will maintain contact and monitor the child to determine whether the adolescent can return to the Demonstration grant waiver program.

States with pre-existing wraparound programs also reported a recruitment advantage. Indiana noted that many of their 40 access sites already had functioning wraparound processes in their community. As a result, many families were already aware of the service delivery method and were very comfortable with the providers of wraparound facilitation in their communities.

Kansas had previously implemented a successful 1915(c) HCBS Serious Emotional Disturbance (SED) Waiver statewide. Due to this existing waiver, much of the infrastructure necessary to effectively implement the PRTF Demonstration grant waiver project was already in place. The PRTF Demonstration grant waiver program provides eight additional service options for children and youth who meet the clinical eligibility criteria of being at imminent risk of placement in a psychiatric residential facility. The PRTF Demonstration grant waiver program can be an alternative for youth with a serious emotional disturbance to remain in their home and receive community based services.

Some States experienced difficulty increasing their participant enrollment, which they attributed to a variety of factors. The reasons included families' skepticism about the new program and reluctance to have their child or adolescent return home. Fiscal and policy concerns also presented difficulties. Due to budget constraints South Carolina was forced to cap enrollment for six months and was close to eliminating the program completely.

Indiana, Kansas, Mississippi, Montana and South Carolina reported having some difficulty retaining participants in the program once enrolled. They attributed their retention challenges to several factors, including poor adherence to waiver services, lack of respite services, and inadequate family buy-in. Each State was taking steps to improve retention including increasing education and outreach to families and restructuring policies that hindered service delivery.

- **The provider base for most States is growing.** Most States successfully increased their provider enrollment over the past year. Some States did this by including new types of agencies as providers. For example, Indiana expanded its provider base beyond community mental health centers to include a range of youth service provider agencies. Other States, like Maryland, have expanded their program to include wider geographic jurisdictions of the State. These expansions are likely to address recruitment limitations due to jurisdiction and provider location reported by some States.

States attributed their increased provider recruitment to different factors including word-of-mouth and using program staff to visit different parts of the State and giving public presentations on the Demonstration grant waiver program. As noted last year, States with pre-existing provider infrastructure from other grant streams (e.g., SAMHSA System of Care grants) continue to build on those networks, making it easier to recruit providers and cover a larger geographic region. For example, Mississippi reported that many providers from its State-funded wraparound pilot sites eagerly stepped forward and enrolled as providers.

States found that enrolled providers responded positively to the program. Alaska reported that prior to the rate increases, some providers were sustaining financial losses serving youth. Nevertheless, one provider agency continued to participate and encouraged other agencies to join due to its strong belief in the program.

- **Financing and reimbursement issues were common barriers to States' provider recruitment**. Although most States reported having made headway in recruiting providers, challenges remained. To mitigate providers' concerns about billing and reimbursement, some States have provided separate training for providers' administrative staff. Alaska and Virginia found that provider reimbursement rates limited providers' participation in the Demonstration grant waiver program. Alaska recently changed State regulations to rectify the reimbursement discrepancy, while Virginia continues to struggle with budget cuts and lower reimbursement rates.

- **States worked to overcome providers' continued misperceptions about the program through education and outreach.** Despite gains over the last year, several States continued to encounter significant resistance from psychiatrists and other providers to participating in the Demonstration grant waiver program. Providers have expressed concerns that participation is time consuming, complicated, requires technical assistance, and/or is a practice liability.

  Maryland noted that some potential providers are reluctant to enroll because they were misinformed. Examples of myths are: waiver program participants will receive priority access to services over their existing clients; waiver participants will require more intensive care than their existing clients; providers need to be a non-profit organization to enroll; and the process of enrolling in the waiver as a provider will be time consuming and complicated.

  To alleviate provider's fears, Maryland addressed each of these "myths" through public presentations, meetings, phone calls, and information posted on the waiver website. Maryland also clarified that Demonstration grant waiver participants are not prioritized over other youth and that the youth population served by the waiver has similar characteristics to the existing clientele. Maryland assured providers that they will be supported by a dedicated care coordinator and a child and family team. Maryland also clarified that only peer support services are required to be provided by non-profit organizations. Finally, Maryland assured providers that once they enroll, extensive one-on-one technical assistance will be available.

States like Montana were finding that providers, as well as some family members, continued to believe that effective care cannot be provided outside of a residential setting. To address providers' misperceptions about the program, States were undertaking a range of education and outreach activities. They posted information on their Web sites and offered trainings, educational panels, and presentations. For example, Montana gave presentations on its wraparound philosophy and practices to providers in each of their Demonstration sites and is planning additional sessions in the future. Similar to Montana, Indiana trained 193 providers on wraparound service delivery to better inform them on the issues.

- **Fiscal crises impacted most States' Demonstration grant waiver programs**. Five States reported that fiscal crises were affecting their program implementation. Maryland noted that it was impacted by employee furloughs and layoffs, as well as reductions in fees for community-based services that have limited resources and overextended staff. Maryland also reported that the total number of beds in public PRTFs was cut due to the budget deficit. In South Carolina, budget cuts have been so dramatic that it had to limit waiver expansion and put holds and caps on enrollment. Virginia also experienced budget cuts and had to reduce the number of covered respite hours and lower rates for environmental modification services. As the fiscal crises persisted, States also continued to face the potential for high staff turnover in State agencies (e.g., due to early retirement buy-outs), which can impact staff's ability to run the program effectively. These issues will likely continue into the program's third year.

- **States continued to grapple with other implementation challenges.** In addition to the issues described above, the States were facing various other challenges as they implemented the Demonstration grant waiver program. These included fragmentation of systems and providers, difficulty aligning multiple processes to enroll participants, limited transitional PRTF referrals, and lack of staff resources.

  Mississippi experienced challenges since implementation of the Demonstration grant waiver started. The State's main challenges involved training Waiver staff and establishing communication protocols among the program's key stakeholders. Mississippi addressed these challenges by putting staff and stakeholders through extensive training, which continues today. Mississippi's Division of Medicaid also established several mechanisms to create open lines of communication among the key players, such as monthly collaborative calls with providers and evaluators, conference participation, and one-on-one face-to-face meetings between Demonstration grant waiver Director and Provider Directors, all of which helped with the overall implementation process.

  Montana experienced challenges in training providers about the wraparound philosophy and practices. Montana wanted providers to understand the services offered through the Demonstration grant waiver. The State offered its two providers on-site training and will continue to provide additional training as needed. Montana was also challenged by administrative problems, such as procuring office space in additional regions and getting these offices operating within the State system.

Maryland addressed its implementation challenges by identifying issues individually with a core group of committed individuals. After identifying key issues, the core group met to problem-solve and identify effective solutions. The group faced many challenges but was ultimately able to get the program running and serving children and youth.

To better address these challenges, some States would like their Demonstration grant waiver plans to be amended to help them better serve their populations. Several States have applied for waiver amendments or requested changes in their State regulations.

Virginia reported implementation challenges stemming from a change in Governor. Due to the change in political climate, the waiver was not a priority and therefore slowed the progress of the waiver for Virginia

- **Despite ongoing challenges, States were documenting numerous successes.** The knowledge gained over the last year led States to achieve greater program successes while encountering fewer challenges. Success factors included effective communications protocols, strong working relationships with key stakeholders, and useful quality improvement efforts that the States developed early in the process.

  Indiana experienced continuous and gradual growth of intensive community-based services throughout the State. The evidence was apparent in its long waiting list of youth who wanted to enroll on the Demonstration grant waiver. Indiana wants to reduce the number of youth on the waiting list by continuing to recruit wraparound facilitators and counties to serve more waiver participants.

  Indiana also noted that the quality improvement initiatives it implemented were positively reflected throughout the Demonstration grant waiver. The quality improvement initiatives were seen in how the State was solving waiver related problems, changing their strategic approaches when necessary, and closely monitoring and providing support to waiver providers. Their quality improvement initiatives were also being used to assist in developing additional infrastructure and support to take the program statewide and sustain it beyond the duration of the grant.

  Mississippi was encouraged by the collaboration and teamwork that the Demonstration grant waiver brought the State. Through working together on the waiver, the staff organized a series of workshops/trainings for service providers, Demonstration grant waiver staff, and evaluators. These efforts have been instrumental in ensuring the consistency of program delivery and functional assessment interviews. The State also knew that if it encountered adverse conditions such as a natural disaster, the providers/frontline workers could ensure the well-being of enrollee youth without formal requests of the Demonstration grant waiver staff.

  Some States have even won awards for their program. Mississippi's grantee team received the Mississippi Conference on Social Welfare Agency Merit Award, which recognizes outstanding work in the area of Social Service and Welfare for the citizens of Mississippi. They were selected for their innovative approach to help seriously emotionally disturbed children stay in their homes and communities for treatment.

More recent successes included improved provider training programs, approved amendments to increase enrollment in waiver, strong provider networks, more effective relationships with PRTFs, and more efficient participant eligibility processes. With additional experience in the coming year, these successes will likely continue and build.

- **Collaboration between the State mental health and Medicaid agencies remained a key success factor.** Since the inception of the waiver program, each State reported a stronger working relationship between their mental health and Medicaid agencies. The continuous interaction between the agencies through regular meetings or working under the same leadership on the waiver fosters and strengthens positive relationships.

- **States were making progress on Minimum Data Set (MDS) data collection.** Most States have finalized their MDS data collection system. Over the past year, seven of the nine States have submitted test, baseline, or follow-up data files.

  Collecting MDS data has not been without difficulties. As discovered last year and reiterated this year, portions of MDS data tend to be scattered across multiple State databases, complicating data collection. Some States were still struggling to collect required MDS data not contained in existing State databases. Two States reported that their data management systems have not been fully operational, forcing them to use paper forms or an Access database to collect data and enter it into the system manually. Specific data collection challenges mentioned by the States included mismatches between routinely collected data and required evaluation items, challenges collecting certain MDS data elements from control groups, delays in data submission by case managers and wraparound facilitators, difficulties obtaining signed consent forms from youth or parents for satisfaction and Wraparound Fidelity Index data, and difficulty collecting termination data from children and youth who left the Demonstration grant waiver grant program.

- **Fewer States than originally planned will be collecting comparison group data.** Although last year nearly all of the States agreed to collect comparison group data, now only Alaska, Indiana, Maryland, Mississippi, and Virginia plan to do so. Alaska and Mississippi have begun enrolling youth in comparison groups. Indiana and Maryland expect to start enrolling comparison youth soon.

  The five States are forming comparison groups in different ways. Four have decided to use children and youth enrolled in PRTFs for their comparison groups. Indiana will create a comparison group from children and youth being served in PRTFs and is also forming a second comparison group comprised of similar children and youth who receive usual public behavioral health services. Virginia is not using children from PRTFs for their comparison group and will construct its comparison group from children who passed initial screening but did not enroll in the Demonstration grant waiver program. At this time, the five States did not anticipate problems gathering comparison group data.

- **Most States will use a local evaluation plan.** Eight of the nine grantee States indicated they have developed a local evaluation plan. Of those eight States, four have submitted, in writing, their plan to the National Evaluators. The level of details varied

across State's plans. For example, contractors, performance measures, baseline information, and statistical techniques were described in some State's plans while others provided a very general description of their methodology.

States that submitted local evaluation	States not submitted BUT say they have local evaluation	States saying they do not have a local evaluation
Indiana	Alaska	Mississippi
Kansas	Georgia	
South Carolina	Maryland	
Virginia	Montana	

- **States were refining methods to meet MDS submission standards.** While a majority of States were meeting the MDS submission deadline, the data often contained errors which could affect the validity of analyses. Few States have submitted data suitable for analysis. The Technical Assistants continued to work individually with the States to ensure future submission meet the MDS guidelines.

Conclusion

As the Demonstration grant waiver program enters its third year, it is clear that all nine States have overcome many implementation challenges and begun providing services to youth in need. While challenges remain, States are showing increasing success in identifying and implementing viable solutions. Increasingly, States are sharing their experiences and solutions with each other through CMS sponsored grantee meetings and in other venues. The limited number of comparison groups and problems with the collection of complete and comparable client outcome data remain challenges for the national evaluation and could make it difficult to complete a conclusive evaluation of the program outcomes in all States. An interim report on program results is to be completed by the end of year three, followed by a final report at the conclusion of the Demonstration grant waiver program. Additional information on the waiver can be found on the CMS website.

Appendix: Planned Demonstration Grant Waiver Administration, Services, Funding, and Enrollment, by State

The tables that comprise this appendix provide individual summaries of each state's approach to Demonstration grant waiver administration, services, funding and enrollment. The content of these tables was extracted from approved Demonstration grant waivers and amendments**.** Actual numbers and costs are not reflected here. For each state, there are three tables:

Table 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS

This table provides information on the management and oversight of the Demonstration grant waiver program in the state. The state line of authority, operating agency, local and regional non-state public entities, contracted entities, and assessment responsibility for local and regional non-state public entities and contracted entities are defined in this table.

Table 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES

This table presents for each year the Demonstration grant waiver services and the projected costs for each service, projected total cost, projected number of clients to be served, projected cost per client, and the anticipated average length of stay.

Table 3: SERVICES

Services for the state appear in this table, along with a description of each service.

The tables provide a snapshot of the Demonstration grant waiver program in each state, and demonstrate the variety of administrative approaches and service delivery methods used across state Demonstration grant waiver programs, as well as the related costs.

ALASKA

ALASKA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	Department of Health and Social Services	Single State Agency for Medicaid
Operating Agency	Department of Health and Social Services – Division of Behavioral Health and Division of Health Care Services	Operationalizing the Implementation of the demo and paying providers
Contracted Entities	University of Alaska, Anchorage Center For Human Development	Perform WFI-4 assessment, gather information from CAFAS, enter into national evaluation forms and submit to CMS
Local-Regional Non-state public entities	N/A	
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	DHSS/DBH	Quality Assurance

ALASKA TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Respite Daily Rate	10,500	41,658	14,729	34,924	40,163	141,976
Supported Employment Development Services	4,860	15,091	72,700	136,199	17,660	246,513
Residential Habilitation	97,600	378,810	736,235	1,159,478	298,350	2,670,474
Professional Training and Consultative Services	16,380	60,552	90,532	121,635	23,797	312,896
Treatment Intervention Mentor Services	151,704	560,764	1,384,230	2,492,921	820,680	5,410,300
Respite Hourly Rate	8,127	32,236	17,185	3,7794	38,799	134,143
Plan of Care Coordination Services	55,396	204,783	484,433	873,465	285,568	1,903,647
Supported Employment Ongoing Supervision	4,644	14,419	75,450	144,169	23,092	261,776
Community Transition Services	666	2,070	7,855	15,707	1,721	28,020
Paraprofessional Training and Consultative Services	18,191	67,221	100,256	134,676	26,129	346,474
Day Habilitation	56,322	223,577	79,423	141,666	66,607	567,597
TOTAL COST	$424,391	$1,601,184	$3,063,033	$5,292,638	$1,642,572	$12,023,820
Clients Served	7	25	53	83	88	
Cost per participant	$60,627	$64,047	$57,793	$63,766	$18,665	
Average Length of Stay	244	244	263	293	80	

ALASKA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Plan of Care Coordination Services	As the treatment and service planning team leaders, Care Plan Coordination Services intensively support Treatment and Intervention Mentors (TIMs), the youth, family, discharging PTRF, FASD diagnostic team, and all other service plan team members to develop an individualized and integrated service plan. Care Plan Coordination Services include facilitation, coordination and development of integrated service plans, in keeping with procedures outlined in section D-1 (Service Plan Development). Documentation of revisions to the plan as needed, assisting and monitoring the youth's progress in functioning, and maintaining fidelity to the "3-M"model are integral parts of this service. Case Plan Coordination Services include clinician oversight of mental health services, supervising TIM service providers and case managers. They also provide support for wraparound services within the "3-M" model. Case Plan Coordinators provide periodic re-assessments to document participant progress toward the goals and assure services are being provided as described in the service plan. The recipient's person-centered plan of care is integrated with the youth's regular mental health services, identifies goals, outcomes, objectives, and issues identified during the intake and needs assessment. Developing the individualized service plan includes determining activities to be completed by each member of the team. in support of the youth and family, including obtaining appropriate health and mental health, social, educational, developmental, and transportation services to meet the youth's needs; coordination, monitoring and clinical oversight of services provided; establishing and maintaining, with individuals and agencies, a referral process that avoids duplication of services to the child and family; planning that identifies needs, goals, objectives, and resources in a coordinated, integrated fashion with the family and other involved agencies; clinical oversight of the implementation of the p1an of care and monitoring its status; and supporting the family to reach the goals of the individualized family service plan while supervising the TIM. Care Plan Coordination Services also include consultation with the family and other team members involved, to monitor whether the services continue to meet the child's and family's needs, making adjustments and revisions based on those observations. These services will assist families of eligible children in gaining access medical or social services identified in the individualized family service plan; coordinate and monitor the delivery of medical or social services that the youth needs or is being provided; inform families of availability of advocacy services; and provide maintenance of a record of care plan coordination activities in each child's file. Case Plan Coordination Services are designed to support the development of effective paid and unpaid mentors within the community that will improve the youth's independent living skills and overall inclusion. This service is provided by a licensed mental health professional clinician operating within their scope of practice or a mental health associate supervised by the clinician.

ALASKA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Day Habilitation	Using the "3 M" modeling and mentoring techniques, Day Habilitation services provide direct assistance with acquisition, retention or improvement of self-help, socialization and adaptive skills (personal grooming and cleanliness, household chores, eating and the preparation of food, etc) that enable the individual to live in a non-institutional setting . Day Habilitation services take place in a non-residential setting separate from the participant's home. Activities, and the environments in which they occur, are designed to foster both appropriate behavior and the acquisition of skills toward a greater independence. Day Habilitation services focus on enabling the participant to attain or maintain the maximum functional level possible and will be coordinated with all other therapies as specified in the integrated service plan. These services are also intended to reinforce skills or lessons taught in other settings.
Residential Habilitation	This service provides individually tailored supports, using the "3-M" techniques of modeling and mentoring, in a home-like residential setting. This assists participants to reach goals in their service plans and assist in the acquisition, retention, and improvement of skills related to independently living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, educational supports, social and leisure skill development so the individual can reside in the most appropriate and community integrated setting possible. Residential Habilitation also includes protective oversight and supervision. Residential habilitation services allow the participant to attain or maintain the maximum functional level possible. Services are also intended to reinforce skills or lessons taught in other settings. Residential habilitation may be furnished where the participant resides whether in their own family home, a foster home or group home. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements for the applicable life safety code. Payment for residential habilitation does not include payments directly or indirectly to members of the individual's immediate family.
Respite Hourly Rate	Respite Care is a service that may be provided to relieve waiver participants' primary unpaid caregivers in the home of the recipient. DBH will not pay for respite services to allow a primary caregiver to work outside the home, provide oversight for additional minor children in the home, or relieve other paid providers of Medicaid services, except for providers of Residential Habilitation in a foster home.

ALASKA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Supported Employment Ongoing Supervision	Supported Employment Services consist of intensive, ongoing support that enable participants ages 14-21, for whom competitive employment at or above the minimum wage is unlikely absent the provisions of supports, and who, because of their FASD and SED, need supports to perform in a regular work setting. Specifically, the Supported Employment-Ongoing Supervision service consists of the provision of long-term extended services needed for job maintenance. Services include an assessment of the waiver recipient's employment stability and what services, including natural and informal supports, are needed to maintain stability; job skills refresher training; social skills training; regular observation at the worksite; troubleshooting and problem solving with the supervisor; facilitation of natural supports in the worksite; and follow-up services such as regular contact with the employer, the individual and the waiver recipient's support team to help strengthen and stabilize the job placement. The recipient's ongoing, extended supported employment plan includes a schedule of hours worked daily, weekly and monthly. The provider will be responsible for checking in with the recipient and/or his employer to ascertain whether the recipient is working the time scheduled and determine both the that individual's and the employer's satisfaction with job performance according to the support schedule outlined in the supported employment plan. Supported Employment-Ongoing Supervision services may include transportation between the recipient's place of residence and the employment site. When Ongoing Supervision services are provided at a work site where persons without disabilities are employed, payment is made only for the supervision and training required by waiver participants. It does not include payment for the supervisory activities rendered as a normal part of the business settings. Ongoing Supervision may also include services and supports that will assist recipients in achieving self-employment through the operation of a business. Medicaid funds will not be used to defray expenses associated with operating the business. Self-employment includes implementation of a long-term support plan that outlines the specific disability-specific and business supports that will be available to assist the individual to maintain and grow his or her business and the number of hours of service provided per month.

ALASKA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Community Transition Services	Services include: security deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control, one time cleaning prior to occupancy, moving fees, furnishings and other items essential for basic independent living outside a licensed facility. Services do not include rent, food, recreational or diversional items such as TV, cable service, VCRs/DVDs, Internet connections or other similar items. Specific services must be detailed, may not exceed $2000 per year and prior authorized in the plan of care. Individual providers will bill for services through the qualified PRTF Waiver Service agencies (including CMHC and HCBS Agencies).
Paraprofessional Training and Consultative Services	Professional Training and Consultative services provide instruction and guidance to families, Mental health staff, teachers, school staff, caregivers and natural community supports to facilitate implementation of the integrated service plans. By providing instruction on effective interventions outlined in the plan for participating youth and how to maintain support within the community, this service helps individuals implementing integrated service plans become effective mentors and behavioral role models. These services are an integral part of developing an informed, effective, community network of individuals focused on supporting youth through the transition to adulthood. Paraprofessional Training and Consultative services are instruction and guidance by qualified staff under the direct supervision of the Professional operating within the scope of their license, to families, teachers, school staff, caregivers and natural community to support and facilitate implementation of integrated service plans and focus on understanding and addressing the participant's needs as outlined in the plan of care. Within this context, specific activities include: instruction and guidance for caregivers, consultation on various specific issues related to recipient's mental health and FASD issues, technical assistance to build support systems and coping skills, and to enhance caregiver skills in implementing, reinforcing and maintaining participant's progress toward care plan. These services are specified and required in the integrated service plan of care and may be provided by paraprofessionals with experience and training in the areas of behavior management, mental health, substance abuse, developmental disabilities, FASD.
Respite Daily Rate	Daily Respite Care is a service provided to primary unpaid caregivers. Respite services may not be used to allow a primary caregiver to work outside the home, provide oversight for additional minor children in the home, or relieve other paid providers of Medicaid services, except for providers of Residential Habilitation in a foster home. DHSS will reimburse for the recipient's room and board expenses during the provision of Respite Care only if the room and board are provided in a PRTF, a licensed assisted living home, or a licensed foster home that is not the recipient's residence.

ALASKA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Supported Employment Development Services	Supported Employment Development Services include support services under a place and train model until employment stability is achieved. At that time, the individual transitions into long term extended Supported Employment service needed for job retention. Development services include: discovery to identify individual strengths leading to individualized job development and customization, benefits counseling, job coaching, job modification, and transportation between the participant's residence and the employment site. When these development services are provided at a work site where persons without disabilities are employed, payment is made only for the supervision and training required by waiver participants but does not include payment for the supervisory activities rendered as a normal part of the business settings. Development also may include services and supports that assist participants in achieving self-employment through the operation of a business. However, Medicaid funds will not be used to defray the expenses associated with starting up or operating the business. Every effort will be made to coordinate services and secure funding for the provision of time-limited supported employment development services (e.g. discovery, benefits counseling, job development and job customization, job coaching) through the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. Documentation will be maintained in the file of each participant if these time-limited services are not available to him or her. All Supported Employment Services, both Development and Ongoing Supervision, consist of intensive, supports that enable participants ages 14-21, for whom competitive employment at or above the minimum wage is unlikely absent the provisions of supports, and who, because of their FASD and SED, need supports to perform in a regular work setting .
Treatment and Intervention Mentor Services	Using an intensive skill development approach, Training and Intervention Mentor (TIM) services provide active intervention with the youth, family, custodial agency, discharging PTRF and FASD diagnostic team to implement an individualized and integrated service plan. The TIM monitors and implements the participant's integrated services plan day-to-day services and includes participation in service delivery and treatment plan meetings. Direct service provision may include implementing a crisis plan, providing wraparound support and ensuring its fidelity to the model, ensuring appointments are attended, arranging transportation, performing functional assessments, assuring that all assessments and evaluations are performed as specified in the service plan according to the model, and providing support and skills development to service providers to ensure successful interventions with the youth and family. These services are performed under the supervision of the Mental Health Professional Clinician.

ALASKA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Treatment and Intervention Mentor Services (continued)	The integrated plan of care includes interventions that alleviate inappropriate and unhealthy behaviors and build social and coping skills needed to alleviate the symptoms of SED experienced by the participant. For youth with co-occurring FASD, the specific method of modeling and mentoring is required to ensure that new behaviors and skills are learned and practiced with subsequent successful integration into the child's life. Modeling within this service involves the use of problem solving with the recipient to determine appropriate approaches to take, introducing the new skill, showing why the skill is useful for the recipient, and how to execute it by showing the steps and so the participant can mimic it. TIM services provide the opportunity and support for repetitively practicing these new skills in the community by engaging in the activities with the participant. Skills modeled by TIMs may include: Socially acceptable and successful ways to make, keep and attend appointments as specified in the plan of care; skills for engaging with educators and counselors in the school setting; techniques for managing emotions and behaviors in stressful situations; techniques for procuring needed items and services from local businesses, libraries, clinics, etc. A behavioral support plan may be also be implemented within this service if specified in the POC, with milestones, achievements, set-backs and revisions all monitored and documented as well. This service involves the service provider accompanying the recipient to model desired behaviors throughout the process until the recipient can perform parts of the activity independently. At that point the focus becomes monitoring progress toward the goal and mentoring to success. This service also includes adapting techniques to adjust for progress or setbacks so that successful completion of goals is ensured. Monitoring and implementing the service plan includes active involvement with the youth and family through modeling living, social, and coping skills for youth and their families while mentoring them to success to ensure that treatment and other activities are provided as described in the service plan and in fidelity with the 3-M model. Activities directly related to the POC are also designed to promote community inclusion. Throughout these planned intervention activities, TIMS facilitate the inclusion of natural supports into the overall plan by coordinating with service agencies mentioned above, other family members, and organizations within the youth's home community (e.g., school staff, church staff, local merchants and others involved in various community activities.) while developing activities with them that further the participants goals as outlined in the service plan. Monitoring progress within this service means continually assessing the participant's functionality either informally or formally at 6 month intervals using the CAFAS assessment tool. Assessment results and contact observations are documented in the participant's record for inclusion in the Integrated Plan of Care and will influence future adjustments to it. TIM service is designed for one provider to serve average caseloads of 3-5, allowing them to provide extensive direct services to participants. Payment will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

GEORGIA

GEORGIA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	Department of Community Health	The State Medicaid agency will be responsible for overseeing the functions performed by the Division and its contracted entities under the waiver.
Operating Agency	Department of Behavioral Health and Developmental Disabilities (DBHDD)	The DBHDD will be responsible for the following functions: dissemination of information concerning the waiver to potential enrollees, enrollment of individuals into the Waiver, monitoring waiver enrollment and expenditures, conducting utilization management, recruiting providers and conducting training and technical assistance. The Division will use its External Review Organization, APS HealthCare to determine PRTF level of care.
Contracted Entities	External Review Organization (ERO)	The ERO's Care Management Unit clinical staff evaluate the information provided, assess the need for HCBS and make a determination of eligibility for 100% of all cases. The ERO employs physicians, nurses and licensed mental health professionals.
	Other, Care Management Entities (Program administration, Provider outreach, data collection) Fiscal Intermediary (Claims Processing) University of Georgia (Evaluation)	The operating agency will utilize other administrative contracts from time to time to assist in program administration, examples could include: use of contracted staff in lieu of employees; training on person-center-planning, effective child and family teams, etc; computer or data consultants to facilitate data collection for the waiver evaluation; evaluation of the waiver; parent peer support development, among others.
Local-Regional Non-state public entities	N/A	
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	DBHDD and the Department of Community Health (DCH)	DBHDD and DCH will be responsible for reviewing the performance of the Medicaid External Review Organization (APS HealthCare) for behavioral health services on an annual basis. APS Healthcare will be responsible for performing reviews of level of care evaluations. DBHDD and DCH will be responsible for reviewing the performance of other operational or administrative contracts.

GEORGIA TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Supported Employment	-	9,580	22,520	49,770	58,540	140,410
Care Management	19,829	620,816	1,094,546	1,834,340	2,161,694	5,731,226
Financial Support	-	7,200	27,900	52,200	54,900	142,200
Consultative Clinical and Therapeutic	18,832	577,973	1,249,090	1,933,221	2,265,389	6,044,505
Community Transition and Supports	7,500	27,000	57,000	90,000	67,500	249,000
Family Training and Supports	6,235	357,135	620,227	1,194,555	1,236,827	3,414,980
Community Guide	-	42,864	83,049	155,382	163,419	444,714
Transportation	1,344	61,387	120,658	205,330	240,610	629,328
Customized Goods and Services	2,000	136,000	300,000	470,000	600,000	1,508,000
Wraparound Services – Unskilled	9,351	572,298	1,124,862	1,914,239	2,324,713	5,945,463
Respite	28,804	533,136	1,047,888	1,719,228	2,089,648	5,418,704
TOTAL COST	$93,894	$2,945,389	$5,747,740	$9,618,264	$11,263,241	$29,668,529
Clients Served	30	87	171	291	341	
Cost per participant	$3,130	$33,855	$33,613	$33,052	$33,030	
Average Length of Stay	103	241	239	206	206	

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Care Management	Care Management Services assist participants in identifying and gaining access to needed waiver and other State Plan Services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained, and encourages the use of community resources through referral to appropriate traditional and non-traditional providers, paid, unpaid and natural supports. Care Management Services are a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, and reviewing the delivery and outcome of appropriate services for participants through a wraparound approach. Care Managers work in partnership with the participant and their family/caregivers/legal guardian and are responsible for assembling the Child and Family Team, including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities and address participant health and safety issues. Care Management Services include the following components as frequently as necessary or at least on an annual basis: Comprehensive assessment and periodic reassessment of the participant to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, or other services and include activities such as: taking client history; identifying the needs, strengths, preferences and physical and social environment of the individual, and completing related documentation; gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the participant. Development and periodic revision of an individualized service plan (ISP), based on the assessment, that specifies the goals of providing care management and the actions to address the medical, social, educational, and other services needed by the participant, including activities that ensure active participation by the participant and others. The care plan will include a transition goal and plan. If a participant declines services identified in the care plan, it must be documented. The care manager is responsible for seeking service plan authorization through the operating agency (DBHDD) with oversight by the Medicaid Agency. Referral and related activities to help the participant obtain needed services, including activities that help link the eligible individual with medical, social, educational providers, and other programs or services that are capable of providing needed services to address identified needs and achieve goals in the care plan.

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Care Management (continued)	Monitoring and follow-up activities that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the participant. Monitoring includes direct observation, and follow up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services and the ongoing evaluation of the satisfaction of waiver participants and their families/caregivers/legal guardians with the ISP. These activities may be with the participant, family members, providers, or other entities, and may be conducted as frequently as necessary, and at least on an annual basis, to help determine: whether services are being furnished in accordance with the participant's service plan; whether the services in the care plan are adequate to meet the needs of the participant; whether there are changes in the needs or status of the participant. If changes are needed, the individual service plan and service arrangements with providers should be changed. Care Management Services may include contacts with non-eligible individuals that are directly related to the identification of the participant's needs and care, for the purposes of assisting participants access to services, identifying needs and supports to assist the participant in obtaining services, providing care managers with useful feedback, and alerting care managers to changes in the participant's needs. Participants will be given choice of qualified providers of care management services. Care Management Services must be authorized prior to service delivery by the DBHDD and at least annually in conjunction with the ISP and any revisions. Care Management - Transition Services may be provided to eligible individuals presently residing in an accredited Psychiatric Residential Treatment Facility (PRTF) who are assigned a waiver slot to assist them in obtaining and coordinating services that are necessary to return them to the community. Care Management - Transition Services may be provided up to 120 days prior to transition. This service must be approved in advance and providers may not bill for this service until the date that the participant leaves the PRTF, and is receiving other waiver services in a community setting.

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Respite	Respite services provide safe and supportive environments on a short-term basis for participants unable to care for themselves because of the absence or need for relief of those persons who normally provide care for the participant. Additionally, Respite Services may be provided for support or relief from the caretaker of the youth participating in the Waiver. This service reduces the risk of out-of-home placements at a higher level of care. Federal financial participation will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite is available twenty-four (24) hours/seven (7) days a week. Respite Services may be in quarter-hour increments or overnight, and may be provided in-home or out-of-home in the following locations: • Participant's home or private place of residence • The private residence of a respite care provider • Foster home • Group home The need and plan for Respite Services must be documented in the approved ISP prior to service delivery at least annually.
Supported Employment	Supported Employment services consist of ongoing supports that enable participants with severe emotional disturbances or mental illness for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their serious mental illness, need supports to perform in a regular work setting. It provides one-to-one intensive on-going supports in preparing for, securing, and maintaining competitive employment in a regular work setting. Supported Employment may include assisting the participant to locate a job or develop a job. Supported employment is provided in a variety of settings, particularly work sites where persons without disabilities are employed. The service includes activities needed to sustain paid work by participants and includes supervision and training. When these services are provided, payment is made only for the special adaptations, supervision, and training required by the participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting. These services are provided to enable eligible individuals to choose, obtain or maintain individualized, competitive employment, in an integrated work environment, consistent with their interests, preferences and skills. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Supported Employment (continued)	2. Payments that are passed through to users of supported employment programs; or 3. Payments for training that is not directly related to an individual's supported employment program. Supported Employment services include transportation of participants to community work sites. Transportation provided through Supported Employment is included in the cost of doing business and incorporated in the administrative overhead cost. Separate payment for transportation only occurs when the distinct Transportation Services are authorized. Supported Employment services must be authorized prior to service delivery at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. Supported employment services may be provided individually or in group settings, and to obtain a job for a participant.
Community Guide	Community Guide Services are designed to empower participants to define and direct their own services and supports. These services are only for participants who opt for participant-direction. The participant determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide. These services must be included in their approved Individual Service Plan. Community Guide Services help participants and their families define and/or direct their own services and supports and to meet their participant-direction responsibilities. It facilitates the participant (or the participant's family or representative, as appropriate) in arranging for, problem-solving and decision making in developing supportive community relationships and other resources that promote implementation of the Individual Service Plan. This service is available to assist participants in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting respite care workers and providing information on effective communication and problem-solving. The service/function also includes providing information to ensure that participants understand the opportunities and responsibilities involved in directing their services. Community Guide services do not duplicate Care Management Services or Financial Management Services. Community Guide services do not include procurement, fiscal and accounting functions included in Financial Management Services. Community Guides cannot provide other direct waiver services, including Care Management, to any waiver participant. Community Guide agencies cannot provide Care Management Services. The specific Community Guide services to be received by a waiver participant are specified in the Individual Service Plan. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a Community Guide for that participant. Community Guide services must be authorized prior to service delivery by the Care Coordinator at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Community Transition Services	Community Transition Services are: non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; and (f) necessary home accessibility adaptations. Additionally, non-recurring expenses to facilitate independent transportation opportunities, such as driver's license, driver's training or vehicle registration in instances where a vehicle has been donated are allowable. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources such as DFCS Independent Living Program, Rehabilitation Act. Community Transition Services do not include monthly rental or mortgage expense; food; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may not be used to pay for furnishing or setting up living arrangements that are owned or leased by a waiver provider.
Consultative Clinical and Therapeutic Services	Consultative Clinical and Therapeutic Services that are not covered by the State Plan and are necessary to improve the participant's independence and inclusion in their community and to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans. Home or community based consultation activities are provided by professionals in psychology, social work, counseling, behavior management or criminology. The service includes assessment, development of a home treatment/support plan, training, technical assistance and support to carry out the plan, monitoring of the participant and other providers in the implementation of the plan and compensation for participation in the Child and Family Team meetings. Crisis counseling and stabilization and family or participant counseling may be provided. This service may be delivered in the participant's home, other community home such as foster care, in the school, or in other community settings as described in the Individual Services Plan to improve consistency across service systems.

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Customized Goods and Services	Customized Goods and Services are individualized supports that youth who have severe emotional disturbances or mental illness may need to fully benefit from mental health services. It includes services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the individual service plan and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. The specific Customized Goods and Services must be clearly linked to a participant behavior/skill/resource need that has been identified and documented in the approved ISP prior to purchase or delivery of services. Goods and services purchased under this coverage may not circumvent other restrictions of waivered services, including the prohibition against claiming for the costs of room and board. The Care Manager may provide support and assistance to the participant/representative in budgeting and directing goods or services to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipt that provides clear evidence of purchase must be on file in the participant's records to support all goods and services purchased. An individual serving as the representative of the waiver participant for whom the goods and services are being purchased is not eligible to be a provider of Customized Goods and Services. A Medicaid enrolled provider of waiver services makes payments to the specified vendors. Customized Goods and Services could include tutoring; parenting skills; homemaker services, structured mainstream recreation, therapeutic or day support activities; mentor or behavioral aid; a utility deposit to help stabilize a child's behavioral health crisis; environmental modification to the participant's residence to enhance safety and ability to continue the living arrangement, among other customized goods and services to provide flexible community services and to maintain stability in their residence.

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Family Training and Supports	Family Training and Support Services are participant centered services with a rehabilitation, recovery and maintenance focus designed to promote skills for coping with and managing mental illness symptoms related to the participant's treatment plan while facilitating the utilization of natural resources and the enhancement of community living skills and participation. These services promote participant socialization, recovery, self-advocacy, development of natural supports, and access to services through information and assistance. Training may include, but is not limited to: individual and group training on diagnosis; medication management; treatment regimens including evidence based practices; behavior planning, intervention development and modeling; skills training; systems mediation and self-advocacy; financial management; socialization; individualized education planning; and systems navigation. Services are directed toward achievement of the specific participant goals defined in the approved Individual Service Plan (ISP), and must be approved by the care manager in advance. Training services are available for individuals who provide support, training, companionship or supervision to participants served in the waiver and these services must be directly related to their role in supporting the participant in the areas specified in the Plan of Care. For purposes of this service, individual is defined as any person, who lives with or provides care to a waiver participant, and may include a parent, caregiver, foster parent, legal guardian, relative, grandparents, family member in the home, family home respite provider, neighbor, friend, companion or natural support who provides uncompensated behavioral care, training, guidance, companionship, or support to a child/youth served in the waiver. Peer or family peer supports may be provided to assist the unpaid caregiver in meeting the needs of the participant. This service may not be provided in order to train paid caregivers or school personnel. FFP is also available as compensation to the providers of this service for participation on the Child and Family Team meetings.

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Financial Support Services	Financial Support Services are services or functions that assist the family or participant to: a) manage and direct the disbursement of funds contained in the participant-directed budget; b) facilitate the employment of staff by the family or participant by performing employer responsibilities as the participant's agent, and c) performing fiscal accounting and making expenditure reports to the participant or family, care manager and state authorities. Financial Support Services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended. The Financial Support Services (FSS) provider receives and disburses funds for the payment of participant-directed services under an agreement with the Department of Community Health, the State Medicaid agency. The FSS provider files claims through the Medicaid Management Information System for participant directed goods and services. Additionally, the FSS provider deducts all required federal, state and local taxes. The FSS provider also calculates and pays as appropriate, applicable unemployment insurance taxes and worker compensation on earned income. The FSS provider is responsible for maintaining separate accounts on each member's participant-directed service funds and producing expenditure reports as required by the Department of Community Health and the Department of Human Resources. When the participant is the employer of record, the FSS provider is the Internal Revenue Service approved Fiscal Employer Agent (FEA). The FSS provider conducts criminal background checks and age verification on service support workers. The FSS provider executes and holds Medicaid provider agreements through being deemed by the state to function as an Organized Health Care Delivery System or as authorized under a written agreement with the Department of Community Health, the State Medicaid agency. The FSS provider must not be enrolled to provide any other Medicaid services in Georgia. Financial Support Services must be authorized prior to service delivery at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.
Transportation	Transportation Services enable waiver participants to gain access to waiver and other community services, activities, resources and organizations typically utilized by the general population, as specified in the Individual Service Plan. These services do not include transit provided through Medicaid non-emergency transportation. Transportation services are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. Whenever possible, family, neighbors, friends or community agencies, which can provide this service without charge, are to be utilized. Transportation services are not intended to replace available formal or informal transit options for participants. The need for Transportation services and the unavailability of other resources for transportation must be documented in the ISP. Transportation services are not available to transport an individual to school (through 12th grade). Transportation to and from school is the responsibility of the public school system or the waiver participant's family. Transportation services must not be available under the Medicaid State Plan, IDEA or the Rehabilitation Act. Transportation services must be authorized prior to service delivery, and must be authorized in the ISP development and with any ISP revisions.

GEORGIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound Services – Unskilled	Services provided to support the individual in the community and increase such participant's independence and control over daily life activities and events, as appropriate to the participant's needs and as specified in the plan of care. Services can be delivered in the participant's home or community setting based on the individual's needs as documented in the plan of care. Services provided may include, but are not limited to: assisting the youth/parent/caregiver in organizing their household to be a safe environment; assistance in activities of daily living such as routine household tasks and household management techniques related to the participant acquiring the skills and competencies to become more self-sufficient; protective oversight and behavioral supervision; providing skills training and supervision for youth to develop and encourage social skills, problem-solving, coping, and life skills development and personal care/hygiene/exercise as identified in the youth's approved individual service plan.

INDIANA

INDIANA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	Indiana Family & Social Services Administration, Office of Medicaid Policy & Planning (OMPP)	The OMPP oversees all executive decisions and all activities related to the demonstration project by reviewing and approving the 1915c application, evaluation plan, operational processes including policies, rules, regulations and bulletins and providing ongoing consultation. OMPP participates with the Advisory Committee and any other related stakeholder work groups. OMPP is also involved in the quality assurance processes, receiving and reviewing evidence-based reports related to the grant which includes information on the Community Mental Health Centers under the contract monitored by DMHA.
Operating Agency	Division of Mental Health and Addiction, Indiana Family and Social Services Administration	DMHA's administrative responsibilities include formal oversight of all operations at the local provider level (community mental health centers and systems of care). In addition to review and approval of each provider and plan of care, this oversight includes at minimum quarterly on-site visits by one or more of the DMHA staff assigned to the project or an individual or agency that contracts with DMHA. These on-site visits include, but are not limited to, observing team meetings, review of provider recruitment activities, review of all public information materials, review of all referrals/requests for services, record reviews, and audits of claims. A written report of each on-site visit will be shared with OMPP. OMPP has the option to request additional information and on-site visits to ensure compliance with operational and administrative functions.

INDIANA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
Contracted Entities	• Surveillance Utilization Review (SUR) • Quality Improvement/Provider Relations • INsite Data Manager • Grant Evaluator is already consultant for DMHA. • Research Assistant • IU Center for Survey Research • Choices, Inc. (training & WFI) • Evaluation Data Manager	Utilization Management Functions: The demonstration grant auditing function has been incorporated into the Surveillance Utilization Review (SUR) functions of the contract negotiated between the Medicaid agency and selected contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate possible problems. The Contractor submits recommendations for review based on their data. The selected contractor's audit process utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and those referred by the state. The youth's eligibility for CA-PRTF Grant services will be validated. On-site visits will be conducted to verify that services billed are authorized in the plan of care, are being delivered, and are meeting the needs of the member. The OMPP will oversee the contractor's aggregate data to identify common problems, determine benchmarks, and provide data to providers to compare against aggregate data. A major focus of the audit exit process will be provider education. Additionally, it is expected that OMPP staff will periodically accompany the contractor on-site, to observe the waiver services.

INDIANA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
Contracted Entities (continued)		Qualified Provider Enrollment Function: The OMPP has a fiscal agent under contract which is obligated to assist the OMPP in processing approved Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid Management Information System for claims processing. This includes the enrollment of approved CA-PRTF providers. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The contract defines the roles and responsibilities of the Medicaid fiscal contractor. Quality Improvement/Provider Relations. Training and Quality Improvement Contractor provides training & consultation to Wraparound Facilitators, observes child and family meetings, and reviews charts for proper documentation. We are in negotiations to hire a second contractor with similar responsibilities. INsite Data Manager is responsible for approving level of care for participants, reviewing and approving plans of care for all participants, enrolling providers into the data system, and running reports. Grant Evaluator (PI) is consultant for DMHA from IU School of Social Work. She oversees the collection, management, reporting and data analysis. Due to the waiver, a Grant Evaluation Data Manager will assist with day to day collection and management of data for the evaluation. This new contractor began November 1, 2009. A Research Assistant from the IUSSW doctoral program also supports the evaluation. IU Center for Survey Research collects and reports YSS data. Choices, Inc. provides wraparound training and administers the WFI-4.

INDIANA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
	Execute the Medicaid provider agreement	The Medicaid agency has a fiscal intermediary under contract (EDS) which is obligated to execute the Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid Management Information System for claims processing. This includes the approved CA-PRTF providers. The contract defines the roles and responsibilities of the Medicaid fiscal contractor.
	Community Mental Health Centers	These private, not-for-profit agencies, contract with Division of Mental Health and Addiction (DMHA), operating agency, to provide continuum of care for children with serious emotional disturbances and youth/adults with serious mental illness. Indiana Administrative Code (440 IAC 4-3-1) defines role and responsibilities of these entities. Specific to this waiver operational and administrative functions, the following will be conducted by these mental health centers: – Disseminate information concerning the waiver to potential enrollees; – Assist individuals in waiver enrollment; – Monitor waiver expenditures against approved levels; and – Recruit providers. Note: Some of Indiana's 30 CMHCs are merging; currently there are 27.
	A variety of child service agencies and providers -	A variety of child service agencies and providers will be recruited to become grant service providers. This may include becoming a local access site.

INDIANA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
Local-Regional Non-State public entities	Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level.	There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	Indiana Division of Mental Health and Addiction (DMHA)	The operating agency, the Indiana Division of Mental Health and Addiction (DMHA), is responsible for assessing the Community Mental Health Centers in their performance of operational and administrative functions. Additionally, DMHA is responsible for assessing the performance of entities contracted to perform quality management, provider development and education, and training activities.
	OMPP	The OMPP exercises oversight and monitoring of the deliverables stipulated within the Surveillance Utilization Review (SUR) contract in order to ensure the contracting entity satisfactorily performs grant auditing functions under the conditions of its contract. Reporting requirements are determined as agreed upon within the fully executed contract. The SUR Contractor is required to submit recommendations for review based on their data. The OMPP Audit Task force meets biweekly to review and approve these recommendations. OMPP oversees the contractor's aggregate data to ID common problems, determine benchmarks and can provide data to providers to compare against aggregate data.

INDIANA TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Consultative Clinical and Therapeutic Services	389,480	218,374	415,216	430,276	428,125	1,881,470
Wraparound Technician	595,992	1,026,884	1,962,303	2,019,681	2,019,681	7,624,541
Habilitation	155,621	1,529,290	2,913,880	3,002,778	2,992,901	10,594,470
Training and Support for Unpaid Caregivers	73,575	71,300	124,190	127,850	127,850	524,765
Non-Medical Transportation	28,400	1,530	2,990	2,990	2,990	38,900
Flex Funds	175,100	492,000	759,900	759,900	759,900	2,946,800
Respite Total	75,552	223,218	419,715	434,035	434,034	1,586,556
Wraparound Facilitation/Care Coordination	1,633,000	2,127,040	4,053,175	4,181,170	4,181,170	16,175,555
TOTAL COST	$3,126,720	$5,689,636	$10,651,372	$10,958,680	$10,946,651	$41,373,058
Clients Served	200	550	750	750	750	
Cost per participant	$15,634	$10,345	$14,202	$14,612	$14,596	
Average Length of Stay	164	153	214	221	220	

INDIANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Habilitation	Habilitation services enhance participant functioning; life and social skills; prevent or reduce substance use/abuse; increase client competencies and build child and family's strengths and resilience, and positive outcomes. This is accomplished through developing skills in identification of feelings; anger and emotional management; how to give and receive feedback; criticism and praise; problem-solving; decision making; assertive behavior; learning to resist negative peer pressure and develop pro-social peer interactions; improve communication skills; optimize developmental potential; address substance abuse and use issues; build and promote positive coping skills; learn how to have positive interactions with peers and adults, encourage therapeutic/positive play with or without parents/guardians, encourage positive community connections, and develop non-paid, natural supports for child and family . Activities are to be conducted face-to-face with the client by a mentor or peer mentor and address the needs of the participant. Habilitation services do not include services that are mandated under IDEA.
Respite	Respite Care services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care may be provided on an hourly basis or a daily basis. The service may be planned and provided on a routine basis (such as weekly, monthly, or semi-annually). Respite Care may also be provided as an emergency in response to a crisis situation in the family. A crisis situation is one where the individual's health and welfare would be seriously impacted in the absence of the Crisis Respite Care. Respite Care may be provided in the participant's home or private place of residence, child care home or facility licensed by the Indiana Family and Social Services Administration, Division of Family Resources or by the Indiana Department of Child Services. Routine, non-crisis, Respite Care may be provided on an hourly basis (billable in 15-minute units) for less than 7 hours in any one day. Or non-crisis Respite Care may be provided at the daily rate for 7 to 24-hours in any one day. Crisis Respite Care is provided for 8 to 24 hours at a daily rate. Respite Care provided in 24-hour units may not exceed 29 consecutive days in any 6 month period. Refer to Appendix C-2e for requirements related to the provision of Respite Care by providers who are related to the CA-PRTF participant. Respite is not provided as a substitute for regular child care to allow the parent/guardian to hold a job. Federal financial participation is available for participation in the child/family team meetings.

INDIANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Consultative Clinical and Therapeutic Services	Consultative Clinical and Therapeutic Services that are not covered by the State Plan and are necessary to improve the participant's independence and inclusion in their community and to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans. Home or community based consultation activities are provided by professionals in psychology, social work, counseling and behavior management. The service includes assessment, development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the participant and other providers in the implementation of the plan. Crisis counseling and family counseling may be provided. This service may be delivered in the participant's home, in the school, or in the community as described in the Plan of Care to improve consistency across service systems.
Flex Funds	Flex funds are utilized to purchase any of a variety of one-time or occasional goods and/or services needed for participants and their families, when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled child's Plan of Care. Flex fund services and/or supports must be described in the person's Plan of Care, and must be related to one or more of the following outcomes: success in school; living at the person's own home or with family; development and maintenance of personally satisfying relationships; prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or becoming or remaining a stable and productive member of the community. Flex funds may be used to purchase non-recurring set-up expenses (such as furniture and bedding or clothing) for children transitioning from PRTF to a family/relative home if the child has been in out-of-home placements for 12 or more months and the Child/Family Team determine that funds are required for this purpose. Funds that are requested for one-time payment of utilities or rent or other re-occurring expenses may be used so long as the family can demonstrate the ability to pay bills in the future. All uses of flex funds must be specified in the Plan of Care and approved prior to being incurred. Claims for flex funds will be submitted through the regular claims process. Documentation must also be included in the clinical record regarding the unavailability of any other funding source for the goods and/or services, the necessity of the expenditure and the outcomes affected by the expenditure. The documentation must also include the wraparound team determination that the expenditure is appropriate and needed in order to achieve the treatment goals and that the expenditure will not supplant normal family obligations. Flex funds may not be used for purely diversional or recreational activities or items. Flex Funds are limited to $2,000.00 per participant per year.

INDIANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Non-Medical Transportation	Transportation services are available to enable CA-PRTF Grant participants and their families to gain access to CA-PRTF grant services and other community services, activities, and resources as specified in the Plan of Care. Transportation may be provided to/from school if the school does not provide transportation, to an approved after school or week-end therapeutic activity, an approved summer camp, and other similar services or activities. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) and does not replace them. Transportation services under the CA-PRTF grant are offered in accordance with the participant's Plan of Care. Federal financial participation is available for the cost of transportation to a training event or conference. Whenever possible, family, friends, neighbors, or community agencies which can provide this service at no charge are utilized. Refer to Appendix C-2e for requirements related to Non-Medical Transportation providers who are a relative or legal guardian of the CA-PRTF participant. Transportation services may not be provided for purely recreational or diversional activities or for any reason not directly tied to the child's plan of care.
Training and Support for Unpaid Caregivers	Training and Support for Unpaid Caregivers is an activity or service that educates, supports, and preserves the family and caregiver unit. Training and Support activities and the providers of these activities are based on the family/caregiver's unique needs and are identified in the plan of care. Activities may include, but are not limited to the following: teaching practical living skills, parenting skills, home management skills, use of community resources, child development, record-keeping skills to assist all caregivers; development of informal support, decision-making skills, conflict resolution, and coping skills; as well as assistance with gaining knowledge, insight, and empathy in regard to the participant's illness, and increasing confidence, stamina and empowerment. Training and Support for Unpaid Caregivers may be delivered by the following types of resources: non-profit, civic, faith-based, professional, commercial, and government agencies and organizations; community colleges, vocational schools, universities, lecture series, workshops, conferences, seminars, on-line training programs; Community Mental Health Centers; and other qualified community service agencies. For purposes of this service, Unpaid Caregiver is defined as any person, family member, neighbor, friend, co-worker, or companion who provides uncompensated care, training, guidance, companionship, or support to a CA-PRTF Grant participant. Reimbursement is available for the costs of registration and training fees, supplies associated with the training and support needs outlined in the plan of care. Reimbursement is available for one-on-one training by providers of this service as specified in the plan of care including the individual provider's attendance at the child-family team meeting. Reimbursement is not available for the costs of travel, meals, and overnight lodging.

INDIANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound Facilitation/Care Coordination	Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry-out the wraparound process. Children/youth who participate in the CA-PRTF Demonstration Project must receive Wraparound Facilitation. Wraparound is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible to assure that the participant's needs and the entities responsible for addressing them are identified in a written Plan of Care. The individual who facilitates and supervises this process is the Wraparound Facilitator (WF). Each WF will maintain a caseload of no more than 10 children, regardless of source(s) of funding (grant, local system of care, etc.). The WF is responsible for completing a comprehensive assessment of the individual, working in full partnership with team members to develop a plan of care, oversees implementation of the plan, identifies providers of services or family based resources, facilitates Child and Family Team meetings, and monitors all services authorized for a child's care. CA-PRTF grant services are authorized for payment based on the plan of care. The WF assures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values, offers consultation and education to all providers regarding the values and principles of the model, monitors progress toward treatment goals, and ensures that necessary data for evaluation is gathered and recorded. The WF ensures that all CA-PRTF grant related documentation is gathered and reported to DMHA as per requirements. The Wraparound Facilitator: • Completes CANS Reassessments every six months to monitor progress. • If the WF is not a QMHP, he/she arranges for a QMHP to complete the annual PRTF LOC re-evaluations with active involvement of the Child and Family Wraparound Team; • Guides transition of the youth to the community from a PRTF; • Guides the engagement process by exploring and assessing strengths and needs; • Facilitates, coordinates, and attends family and team meetings; • Guides the planning process by informing the team of the family vision (no team meeting without family); • Guides the crisis plan development, monitors the implementation and may intervene during a crisis; • Authorizes and manages Flex Funding as identified in the Plan of Care; • Assures that the work to be done is identified and assigned to a team member;

INDIANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound Facilitation/Care Coordination (continued)	• Assures that a written Plan of Care is developed, written and approved by the Division of Mental Health and Addiction; • Reassesses, amends, and secures on-going approval of Plan of Care; • Communicates and coordinates with local Division of Family Resources (DFR) regarding continued Medicaid eligibility status; • Monitors cost-effectiveness of Medicaid services; • Monitors and supervises the Wraparound Technician; • Guides the transition of the youth from the demonstration project. Wraparound Facilitation does not duplicate Wraparound Technician services or any other Grant or state plan Medicaid service. Every child/family will have a WF. The WF may perform the tasks identified for a Wraparound Technician. This will occur when the caseload does not warrant an added person to perform all the duties of the Wraparound Technician. Both WF and Wraparound Technician services include assistance to participants in gaining access to services (CA-PRTF Grant, medical, social, educational and other needed services). The difference between these two services is related to the complexity of the activities. The WF manages the entire wraparound process and ensures that all assessments/reassessments are completed; ensures that the plan of care is completed (including a crisis plan) and is approved; guides all team members to ensure that the family vision is central to all services; manages the flex fund; and supervises the Wraparound Technician.
Wraparound Technician	The Wraparound Technician applies the theories and concepts of the wraparound process and the resulting Plan of Care to the child/youth's day to day activities. Wraparound Technicians are guided and supervised by the Wraparound Facilitator. They discuss progress with other team members, providers, and family and make recommendations to the Wraparound Facilitator and team. • Participate in Child and Family Team meetings; • Monitor progress by communicating with the family and child, as well other team members and the Wraparound Facilitator. The timetable for and the mode of communication should be determined with the family; • Assist the family and child with gaining access to services and assure that families are aware of available community-based services and other resources such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs; • Monitor use of service and engage in activities that enhance access to care, improve efficiency and continuity of services, and prevent inappropriate use of services; • Monitor health and welfare of the child/youth; • May provide crisis intervention; • May facilitate Medicaid certification and enrollment of potential providers identified by the family to provide demonstration project services.

INDIANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound Technician (continued)	Wraparound Technician may not duplicate Wraparound Facilitation or any other Grant or state plan Medicaid service. However, the Wraparound Technician functions may be provided by the same individual who provides Wraparound Facilitation services. THIS EXCLUDED RESPITE CARE which has existed from the original grant. Current definition added below: Respite Care services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care may be provided on an hourly basis or a daily basis. The service may be planned and provided on a routine basis (such as daily, weekly, monthly, or semi-annually), or may be unplanned when a caregiver has an unexpected situation requiring assistance in caring for the participant. Respite Care may also be provided as an emergency in response to a crisis situation in the family. A crisis situation is one where the individual's health and welfare would be seriously impacted in the absence of the Crisis Respite Care. Respite Care services may be provided in the participant's home or private place of residence, or any facility licensed by the Indiana Family and Social Services Administration, Division of Family Resources or by the Indiana Department of Child Services under: 1) Emergency shelters licensed under 465 IAC 2-10; 2) Special needs foster homes licensed under IC 31-27-4; 3) Therapeutic foster homes licensed under IC 31-27-4; 4) Other child caring institutions licensed under IC 31-27-3; 5) Child Care Centers licensed under IC 12-17.2-4 or Child Care Homes, licensed under IC 12-17.2-5-1 or School Age Child Care Project licensed under IC 12-17-12; or 6) Medicaid certified PRTF under 405 IAC 5-20-3.1 and licensed under 465 IAC 2-11-1 as private secure residential facility. Respite services must be provided in the least restrictive environment available and ensure the health and welfare of the participant. A participant who needs consistent 24-hour supervision with regular monitoring of medications or behavioral symptoms should be placed in a facility under the supervision of a psychologist, psychiatrist, physician or nurse who meets respective licensing or certification requirements of his/her profession in the state of Indiana. Respite Care may be provided on an hourly basis (billable in 15-minute units) for less than 7 hours in any one day; or at the daily rate for 7 to 24-hours in any one day. Crisis Respite Care is provided for a minimum of 8 to 24 hours billable at a daily rate. Twenty-four hour Respite Care cannot exceed 14 consecutive days.

KANSAS

KANSAS TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	Kansas Health Policy Authority (KHPA)	Kansas Health Policy Authority (KHPA) is the final authority on compensatory Medicaid costs. Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities. • Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds • Requires the SSMA to provide SRS with professional assistance and information; and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process. • Specifies that the SSMA has final approval of regulations, SPAs and MMIS policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with SRS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship: Core concepts were developed through an interagency work group that involved program and operations staff from both the SSMA and SRS; functional pieces of the waiver were developed by SRS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)

KANSAS TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
SERVICE	**DESCRIPTION**	
Operating Agency	Kansas Department of Social and Rehabilitation Services (SRS)	KHPA delegates to SRS, the authority for administering and managing certain Medicaid funded programs, including those covered by this waiver application.
Contracted Entities	Kansas Health Solutions	The Kansas Contractor, Kansas Health Solutions, will manage and deliver all Medicaid outpatient mental health services, rehabilitation services, and the HCBS PRTF CBA Home and Community Based Services or Home and Community Based Services under the HCBS-SED waive.
Local-Regional Non-State public entities	Kansas Community Mental Health Centers	Kansas Community Mental Health Centers as defined by statute KSA 75-3307c, are the non-state local entity that performs certain waiver operational and administrative functions. Each of the twenty seven Community Mental Health Centers contract with Kansas Health Solutions to provide mental health services to Medicaid members. The functions are outlined in #7 below.
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	Kansas Department of Social and Rehabilitation Services	

KANSAS TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Attendant Care	297,600	883,200	1,167,360	1,543,680	1,969,920	5,861,760
Parent Support and Training	53,604	122,532	166,728	231,852	349,704	924,420
Employment Preparation/Support	186,290	661,500	1,165,250	1,788,000	2,294,600	6,095,640
Professional Resource Family Care (Crisis Stabilization)	149,040	1,018,440	1,490,400	1,937,520	3,142,260	7,737,660
Community Transition Supports	27,000	72,000	153,000	189,000	225,000	666,000
Wrap Around Facilitation	96,640	271,360	354,560	456,320	614,400	1,793,280
Short Term Respite Care	90,000	272,400	403,200	435,600	556,800	1,758,000
Independent Living/Skills Building	16,560	40,320	68,400	86,400	110,880	322,560
TOTAL COST	$916,734	$3,341,752	$4,968,898	$6,668,372	$9,263,564	$25,159,320
Clients Served	189	523	662	840	1,067	
Cost per participant	$4,850	$6,390	$7,506	$79,393	$8,682	
Average Length of Stay	270	270	270	270	270	

KANSAS TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Attendant Care	Services provided to a consumer with a serious emotional disturbance that would otherwise be placed in a more restrictive setting due to significant functional impairments resulting from an identified mental illness. This service enables the consumer to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Assistance is in the form of direct support, supervision and/or cuing so that the consumer performs the task by him/her self. Such assistance most often relates to performance of Activities for Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community. The majority of these contacts must occur in customary and usual community locations where the consumer lives, works, attend schools, and/or socializes. Services provided at a work site must not be job tasks oriented. Services provided in an educational setting must not be educational in purpose. Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease are non-covered. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the consumer's individualized plan of care. Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this services. Attendant Care does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.
Employment Preparation/ Support	Employment Preparation/Support services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Employment Preparation/Support may include assisting the participant to locate a job or develop a job on behalf of the participant. Employment Preparation/Support is conducted in a variety of settings; particularly work sites where persons without disabilities are employed. Employment Preparation/Support includes activities needed to sustain paid work by participants, including supervision and training. Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this service. Employment Preparation/Support does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

KANSAS TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Employment Preparation/ Support (continued)	Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.
Independent Living/Skills Building	Independent Living/Skills Building services are designed to assist consumers who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings. Independent Living/Skills Building activities are provided in partnership with young consumers to help the consumer arrange for the services they need to become employed, find transportation, housing, and continuing education. Services are individualized according to each consumer's strengths, interests, skills, goals, and are included on an individualized transition plan (i.e. Wavier Plan of Care). It would be expected that Independent Living/Skills Building activities take place in the community. This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living. Housekeeping, homemaking (shopping, child care, and laundry services), or basic services solely for the convenience of a consumer receiving independent living/skills building are noncovered. An example of community settings could encompass: a grocery or clothing store, (teaching the young person how to shop for food, or what type of clothing is appropriate for interviews), unemployment office, (assist in seeking jobs, assisting the youth in completing applications for jobs), apartment complexes, (to seek out housing opportunities), Laundromats,(how to wash their clothes) etc. These services can be provided in any other community setting an appropriate service as identified through the Plan of Care process. This is not an all inclusive list. Transportation is provided between the participant's place of residence and other services sites or places in the community and the cost of transportation is included in the rate paid to providers of this service. Independent Living/Skills Building does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

KANSAS TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Short Term Respite Care	Respite Care provides temporary direct care and supervision for the consumer. The primary purpose is relief to families/caregivers of a consumer with a serious emotional disturbance. The service is designed to help meet the needs of the primary caregiver as well as the identified consumer. Normal activities of daily living are considered content of the service when providing respite care, these include: support in the home/after school/or at night, transportation to and from school/medical appointments/or other community based activities, and/or any combination of the above. The cost of transportation is included in the rate paid to providers of this services. Short Term Respite Care can be provided in an Individual's home or place of residence or provided in other community settings. Other community settings include: Licensed Family Foster Home, Licensed Group Boarding Home, Licensed Attendant Care Facility, Licensed Emergency Shelter, Out-Of-Home Crisis Stabilization House/Unit/Bed. Respite Services provided by or in an IMD are non-covered. The consumer must be present when providing Short Term Respite care. Short term Respite care may not be provided simultaneously with Professional Resource Family Care (Crisis Stabilization) Services and does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost. FFP is not claimed for the cost of room & board.
Community Transition Supports	Community Transition Supports are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household, which does not constitute room and board, and may include: Security deposits, essential household furnishing and moving expenses, and set up fees for utilities. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.
Parent Support and Training	Parent Support and Training is designed to benefit the Medicaid eligible member experiencing a serious emotional disturbance who without waiver services would require state psychiatric hospitalization. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process. The Parent Support Worker assists with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the Medicaid family member. Training involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the member in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management; assisting the family in understanding various requirements of the waiver process, such as the crisis plan and plan of care process; training on the member's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the member with mental illness while living in the community.

KANSAS TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Parent Support and Training (continued)	For the purposes of this service, "family" is defined as the persons who live with or provide care to a member served on the waiver, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the member's individualized plan of care. Parent Support and Training does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.
Professional Resource Family Care (Crisis Stabilization)	Professional Resource Family Care (Crisis Stabilization) is intended to provide short-term and intensive supportive resources for the member and his/her family. The intent of this service is to provide a crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the member by responding to potential crisis situations through the utilization of a co-parenting approach provided in surrogate family setting. The goal will be to support the member and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the member, there is regular contact with the family to prepare for the member's return and his/her ongoing needs as part of the family. It is expected that the family and the professional resource family are critical participants of the member's individual treatment team. Transportation is provided between the member's place of residence and services sites. The cost of transportation is included in the rate paid to providers. FFP is not claimed for the cost of room & board. Professional Resource Family Care (Crisis Stabilization) may not be provided simultaneously with Short term Respite care and does not duplicate any other Medicaid State Plan Service or service otherwise available to a member at no cost.

KANSAS TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
WrapAround Facilitation	The function of the Wraparound Facilitator is to form the wrap-around team consisting of the member's family, extended family, and other community persons involved with the member's daily life for the purpose of producing a community-based, individualized Plan of Care. This includes working with the family to identify who should be involved in the wrap-around team and assembly of the wrap-around team for the Plan of Care development meeting. The Wraparound Facilitator guides the Plan of Care development process of the team to assure that waiver rules are followed. The Wraparound facilitator also is responsible for reassembling the team when subsequent Plan of Care review and revision are needed, at minimum on a yearly basis to review the Plan of Care and more frequently when changes in the member's circumstances warrant changes in the Plan of Care. The Wraparound Facilitator will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the member and family/caregivers. Facilitators will be certified after completion of specialized training in the Wraparound Philosophy, waiver rules and processes, Waiver eligibility and associated paperwork, structure of the member and Family Team, and meeting facilitation. Wraparound Facilitation is provided in addition to targeted case management to address the unique needs of waiver members living in the community and does not duplicate any other Medicaid State Plan Service or services otherwise available to the member at no cost. COMPARISON OF SERVICES: Targeted Case Management vs. Wraparound Facilitation/Community Support. The following indicates contrasts between the two services of case management and wraparound support facilitation:

KANSAS TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
WrapAround Facilitation (continued)	EMPLOYER: Target Case Manager: Works for a single service provider agency such as a community mental health center. Wraparound Facilitator: Can work for one of a number of agencies or be independent of a particular service provider. Affiliation status with a regional interagency coordinating council or community interagency team. TASKS: Targeted Case Manager: Develops treatment plans for community mental health center services. Coordinates and refers to existing resources. Responsibility to track outcomes for CMHC services. Does not have costs or budgetary authority. Wraparound Facilitator: Assists the family with identifying the wrap-around team and facilitates the wrap-around meeting/process including the assisting the wrap-around team with the development of the individualized plan of care. Prior Authorizes the ePOC. Plans that are developed include costs and budget authority. No responsibility to track outcomes. Assists the Wrap Around Team with updating the HCBS Waiver individualized plan of care as needed and coordinates reviews of the plan of care. TRAINING: Targeted Case Manager: Completion of Community Based Services Core within 6 months of hire, and the Live Interactive Community Event Training for Children's Mental Health Providers within a year of hire. Wraparound Facilitator: Completion of Wrap Around Facilitators Training (WAFT) within 6 months of hire. QUALIFICATIONS: Targeted Case Manager: Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience substituting for one year of education; Will have demonstrated interpersonal skills, ability to work with children or adolescents with SED, and the ability to react effectively in a wide variety of human serve situations. Pass KBI, SRS child abuse check, Adult abuse registry and motor vehicle screens. Receive ongoing supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP). Wraparound Facilitator: Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience substituting for one year of education. Completion of Wrap-Around Facilitation/Community Support Training according to a curriculum approved by SRS within 6 months of hire. Pass KBI, SRS child abuse check, Adult abuse registry and motor vehicle screens. Receive ongoing supervision by a person meeting the qualifications of a Licensed Mental Health Professional (LMHP). Must be employed by an agency affiliated with a regional interagency council or community interagency team (as established by state statute KSA 39-1701 et seq.

MARYLAND

MARYLAND TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	Maryland Department of Health and Mental Hygiene	DHMH is the single state Medicaid agency authorized to administer Maryland's Medical Assistance Program. DHMH's Office of Health Services (OHS) oversees this waiver through its Division of Waiver Programs (DWP). In this capacity, OHS oversees the performance of MHA, operating state agency for the waiver.
Operating Agency	Mental Hygiene Administration, DHMH	MHA oversees the public mental health system, contracted entities responsible for project management and evaluation, and the Administrative Service Organization.
Contracted Entities	Contracted Project Director	The Project Director will be responsible for overseeing the implementation of the waiver in the jurisdictions. The Director's responsibilities will include, but not be limited to, providing technical assistance, quality assurance, data collection and analysis, program evaluation, financial oversight, and waiver management. MHA will be the signatory on the contract.
	Administrative Service Organization	An administrative services organization (ASO) will be contracted by MHA to manage the public mental health system. The ASO will determine medical eligibility, pay providers through MMIS, and manage the complaint and appeal process for MHA. MHA will be the signatory on the contract with the ASO.

MARYLAND TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
	Care Management Entity (CME)	The Care Management Entity is designated by MHA to serve as an administrative organization responsible for providing care coordination to support the development and implementation of individualized plans of care (POC) by Child and Family Teams and developing a network of clinical and natural supports in the community to support the needs identified in the local service area and specified in each POC. The CME will also serve as the initial point of entry into the waiver, working with families, youth and referring agencies to support participants through the eligibility determination process. The CME will also provide required information to DHMH for the purposes of the demonstration project evaluation. The CME will work with Managed Care Organizations (MCO) to ensure that participants receive access to somatic health services and resources. The State, local/regional non-state public agencies, and/or local/regional non-governmental non-state entities will contract with the CME.
Local-Regional Non-State public entities	Local Management Board	A local management board (LMB) is either a quasi-public nonprofit corporation that is not an instrumentality of county government or a public agency that is an instrumentality of county government, designated by each Maryland county and Baltimore City to ensure the implementation of a local interagency service delivery system for children, youth and families. LMBs may be contracting with the CMEs under the waiver and may assist the State in quality assurance and monitoring efforts. LMBs also provide a source of referrals to the waiver and assist in communicating to the public about the waiver.

MARYLAND TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	ASO	An administrative services organization is contracted by MHA to manage the public mental health system. The ASO determines level of care (LOC) using medical necessity criteria. MHA assigns a contract monitor for the administrative services organization. Representatives of MHA leadership, the ASO, and the assigned project monitor meet regularly to review contract compliance. Additionally, through quarterly meetings with MHA and the Office of Health Services, areas of concern are addressed and MHA ensures follow up with the ASO's contract monitor. MHA communicates the results and any remedial action to OHS.
	University of Maryland	MHA is responsible for the performance of the contracted project director and the evaluators at UMB. Performance indicators will be identified and outlined in a contract between MHA and the University of Maryland.
	CME	Performance indicators will be identified and outlined in a contract between MHA and the CME, or between MHA and the signatory on the contract with the CME.
	LMB	Performance indicators are identified and outlined in a contract between the Governor's Office for Children, on behalf of the Children's Cabinet which includes the Department of Health and Mental Hygiene, and LMBs.

MARYLAND TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
In-Home Respite	1	471,100	565,200	593,600	623,200	2,253,100
Family and Youth Training	0	283,500	340,200	357,192	375,048	1,355,940
Out-of-Home Respite	0	281,769	338,131	355,027	372,787	1,347,714
Crisis and Stabilization Service	0	882,000	1,058,400	1,111,320	1,166,894	4,218,614
Youth Peer-to-Peer Support	0	280,000	336,000	352,832	370,432	1,339,264
Caregiver Peer-to-Peer Support	0	350,000	420,000	441,040	463,040	1,674,080
Expressive and Experiential Behavioral Services	0	386,505	463,824	487,008	511,344	1,848,681
TOTAL COST	$1	$2,934,875	$3,521,755	$3,698,019	$3,882,746	$14,037,395
Clients Served	1	70	80	80	80	
Cost per participant	$1	$41,927	$44,022	$46,225	$48,534	
Average Length of Stay	1	310	360	360	360	

MARYLAND TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
In-Home Respite	Respite Services are temporary care which is arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. These services may be provided in the home or the community. The child or youth will be residing in his or her family home (biological or kin), legal guardian's home, pre-adoptive/adoptive, foster home, or treatment foster home when in-home respite services are provided. ********** "Respite care" means services that are: (1) Provided on a short-term basis in a community-based setting; and (2) Designed to support an individual to remain in the individual's home by: (a) Providing the individual with enhanced support or a temporary alternative living situation, or (b) Assisting the individual's home caregiver by temporarily freeing the caregiver from the responsibility of caring for the individual (3) Designed to fit the needs of the individuals served and their caregivers; and (4) Delivered by individuals who are enrolled by the program to provide a particular service. A program may provide respite care services as needed for an individual based on the Child/Youth Family Team's Plan of Care. The Plan of Care should outline duration, frequency, location and be designed with a planned conclusion. It should include: (1) A schedule of the individual's activities during respite, (2) When needed, medication monitoring, (3) The frequency and intensity of staff support, (4) The respite locations, and (5) The aftercare plan or recommendations.

MARYLAND TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Caregiver Peer-To-Peer Support	Caregiver Peer-To-Peer Support delivered by a Family Support Partner will: • Explain role and function of the Family Support Organization (FSO) to newly enrolled Care Management families. • Work with the family to identify and articulate their concerns and needs • Ensure family voice is incorporated into Child/Youth Family Team process and Plan of Care through communication with Care Manager and Team Members. • Accompany the family to Child/Youth Family Team meetings to support family voice and choice. • Listen to the family express needs and concerns from peer perspective and offer suggestions for engagement in Care Management process. • Provide ongoing emotional support, modeling and mentoring during all phases of the Child/Youth Family Team process. • Help family identify and engage natural support system and other community resources. • Facilitate the family attending peer group and other FSO activities throughout POC process. • Work with the family to organize, and prepare for meetings in order to maximize the family's participation in meetings • Support family in meetings at school and other locations in the community and during court hearings. • Empower family to make choices to achieve desired outcomes for their child or youth, as well as the family. • Help the family acquire the skills and knowledge needed to attain self-efficacy. • Along with a Care Manager and Youth Support Partner make a joint engagement visit (within 72 hours) to families enrolled in Care Management. If this is not possible, Family Support Partner and Youth Support Partner will make separate visits. • Notify Care Manager of critical incidents and when they are no longer involved with families. Care Manager will timely notify Family Support Partners of team meetings, rescheduled meetings, and critical incidents. The following activities are provided to families who request FSO services: • Assistance in understanding all phases of the Child/Youth Family Team process and in communicating family needs to Care Manager and Team Members. – Supporting, modeling and coaching families to help with their engagement in Care Management process; – Community resource linkage; – Support during meetings at school and other locations in the community and during court hearings. – Linkage to peer network – Information and education on procedures to access services and, if needed, assistance with securing needed services. – Consultation, if needed, to Care Managers on ISP management after discussion with families. – Planning for transition from the Child/Youth Family Team process to ensure continued success.

MARYLAND TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Crisis and Stabilization Service	"Crisis and Stabilization Services" are interventions for participants and families that: (a) Are offered in response to urgent mental health needs; (b) Are available on an on-call basis 24 hours per day, 7 days per week; (c) Are coordinated through the Care Coordinator and Child and Family Team and are incorporated into the participant's Plan of Care; (d) Are short-term, flexible services that assist in de-escalating crises and stabilizing children and youth in their home and community setting; (e) Are designed to maintain the child or youth in his or her current living arrangements, to prevent movement from one living arrangement to another and to prevent repeated hospitalizations; (f) Include the delivery of a variety of flexible services in accordance with a comprehensive, individualized plan for stabilization that: (i) Addresses safety concerns and risk factors, including the family's definition of the crisis; (ii) Includes family triggers, strengths, and supports; and, (iii) Identifies both immediate and continued interventions to ensure stabilization in the home and community setting, which may include strategies to de-escalate and prevent a crisis situation, short-term in-home therapy, behavioral management and support, coordination and development of natural supports, and skills training on coping and activities of daily living.
Expressive and Experiential Behavioral Services	Expressive and Experiential Behavioral Services involves action on the part of the provider and the participant. It includes an understanding of psychotherapeutic systems at both nonverbal and a verbal level as necessary in exploring the developmental properties inherent in the art process. Expressive and Experiential Behavioral Services are a group of techniques that are expressive and creative in nature. The aim of creative therapeutic modalities is to help participants find a form of expression beyond words or traditional therapy, such as cognitive or psychotherapy. They include techniques that can be used for self-expression and personal growth. Experiential and Expressive Therapeutic Services include: • Art Behavioral Services • Dance/Movement Behavioral Services • Equine-Assisted Behavioral Services • Horticultural Behavioral Services • Music Behavioral Services • Psychodrama/Drama Behavioral Services

MARYLAND TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Family and Youth Training	Family and Youth Training shall be provided as specified in the participants Plan of Care (POC) through the Child/Youth and Family Team Process. Family and Youth Training may include, but is not limited to: – Individual and group training on diagnosis, – Medication management, – Treatment regimens including Evidence Based Practices, – Behavior planning, intervention development, and modeling, – Skills training, – Systems mediation and self advocacy – Finance Management – Socialization – Individualized Education Planning – Systems Navigation Training normally involves a curriculum or defined set of experiences which will promote usable learning and skill development
Youth Peer-To-Peer Support	Peer- To-Peer Support delivered by a Youth Support Partner will do some are all of the following, depending on the Plan of Care: • Provide explanation of role and function of Youth Support to newly enrolled families • Ensure youth voice is incorporated into planning process through communication with Care Coordinator and Family Support Partner • Work with the youth to articulate their own needs and concerns • Encourage and support youth in participating and guiding the Child/Youth Family Team process • Listen to youth needs, concerns from peer perspective, offering suggestions for engagement in Care Management process • Provide assistance in understanding plan of care process and in communicating youth needs to Child/Youth Family Team (CFT) • Provide consultation, if needed, with CFT regarding planning process after discussion with youth • Accompany youth to CFT meetings or other meetings as needed for support • Provide ongoing emotional support for youth to engage in CFT process • Support youth in preparing for CFT meetings • Help educate the youth about the systems he or she is involved with • Help youth identify and engage natural support systems and other community resources

MARYLAND TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Youth Peer-To-Peer Support (continued)	• Encourage, refer youth to attend peer group and other youth activities throughout planning process • Link youth to community resources and a peer network • Linkage to youth leadership development opportunities • Provide assistance planning for transition out of Care Management • Facilitate the youth attending youth activities • Empower the youth to make choices in a way that is developmentally appropriate in order to guide the team process • Help the youth acquire the skills and knowledge needed to attain resiliency
Out-of-Home Respite	Out-of-Home Respite Services are temporary care which is arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. Out-of-home respite is provided in a facility that is appropriately licensed, registered, or approved, based on: (a) The age of individuals receiving services, and (b) Whether the respite has capacity to do overnight services.

MISSISSIPPI

MISSISSIPPI TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
CATEGORY	**ORGANIZATION**	**ROLE**
State Medicaid or Operating Agency	Mississippi Division of Medicaid – Health Services/Bureau of Mental Health Programs	Waiver Administration and Oversight
Contracted Entities	1. The Utilization Management/Quality Improvement Organization (UM/QIO)	(UM/QIO) is responsible for conducting pre-certification and concurrent review determinations for Medicaid-covered services, including Psychiatric Residential Treatment Facility (PRTF) services and services under the 1915 (c) waiver for youth with Serious Emotional Disturbance. The UM/QIO will be responsible for administrative functions on behalf of the Medicaid agency. The UM/QIO will not provide direct services and will not perform assessments or evaluation. Therefore, there is no identified conflict of interest. The UM/QIO will provide informational workshops and educational programs for providers. Educational programs are available to providers through one-on-one meetings, telephone conferences, web casts and workshops. The UM/QIO provides a reconsideration process for any beneficiary, facility, or physician who receives a Utilization Review Denial Notice the opportunity to request and receive a reconsideration of a determination. The UM/QIO advises any involved party (beneficiaries, representatives, providers, and physicians) in writing, of all initial denial determinations. All parties are notified of the right to request reconsideration and the timeframes for submitting a request. Any party who receives a denial notice and disagrees with the determination may request a reconsideration of the determination.

MISSISSIPPI TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
CATEGORY	**ORGANIZATION**	**ROLE**
Contracted Entities (continued)	2. The Parham Group, Nonprofit Advisors	The Parham Group will perform the services such as assisting and facilitating the development of the required implementation plan. The Parham Group will also assist and facilitate the development of the Request for Proposals for the waiver providers, an RFP evaluation or rating instrument, and assist with the waiver provider selection process. The Parham Group will coordinate and facilitate the identification of professional service needs (such as evaluation services and training/technical assistance services), appropriate and qualified providers, and the development of professional service contracts. The Parham Group will provide additional administrative, project integrity, and advisory services.
Local-Regional Non-state public entities	Community Mental Health Centers (CMHCs)	The CMHCs will be responsible for performing the functional assessments required for the National Evaluation. These functional assessments will also be used to develop the ISP/POC and will be used by the QIO in the re-determination process for the PRTF Level of Care. The State will pay for the cost of these services through an existing provider agreement with the local CMHCs which provide services under the rehabilitation option of the MS State Plan and the MS Code 43-13-117.

MISSISSIPPI TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Wraparound	3,240,000	5,400,000	8,505,000	10,418,625	15,627,600	43,191,225
Functional Assessment	60,000	100,000	157,500	192,850	289,410	799,760
Respite	80,000	200,000	252,000	330,750	347,287	1,210,037
Case Management	1,512,000	2,520,000	3,969,000	4,862,025	7,293,060	20,156,085
TOTAL COST	$4,892,000	$8,220,000	$12,883,500	$15,804,250	$23,557,358	$65,357,107
Clients Served	120	350	450	500	550	
Average Cost per participant	$40,767	$41,100	$42,945	$45,155	$47,115	
Average Length of Services	270	270	270	270	270	

MISSISSIPPI TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Case Management	Case management is defined as services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case management providers under the MS HCBS SED waiver will be Primary Service Coordinators (PSC). The PSC will be responsible for the ongoing monitoring of the provision of services included in the participant's service plan and/or participant health and welfare. Case management may be provided to an individual who is currently in a PRTF in order to facilitate their transition to the community through the use of case management by the PSC. However, the PSC may not bill the DOM for case management until the individual is enrolled in the waiver. The individual who will provide case management as a PSC must meet the minimum standards as established by the MS Department of Mental Health (DMH) and the agency must be certified by the DMH as a case management provider. MS will enroll agency providers. The case load size per individual will be 12-15 as recommended by the Child Welfare League of America. Each participant in the waiver will be assigned a single person as their PSC.
Respite	Respite is defined as services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. MS will provide in-home respite as a service defined under wraparound. Respite as a direct service will be out-of-home Respite in either a PRTF or an acute psychiatric unit of a hospital. FFP will be claimed for room and board when respite is provided in these locations, as allowed by CMS. Respite in a PRTF or acute psychiatric unit of a hospital will be limited to 29 consecutive days per episode and 45 days per State fiscal year. During the 29 consecutive days allowed for respite, the wraparound provider and the State Division of Medicaid (DOM) will share the cost of the care. For PRTF respite, the provider of wraparound services will pay for the first 9 days of PRTF respite. The next 10 consecutive days will be paid as respite by DOM. The final 10 consecutive days will be paid by the wraparound provider. For Respite in an Acute Psychiatric Unit of a hospital, the wraparound provider will pay for days 1-3. DOM will pay the cost for days 4-14 at a per diem rate. The wraparound provider will pay for days 15 – 29. The 29 consecutive days and 45 days per fiscal year limit may be met with a combination of PRTF Respite and Acute Psych Respite.

MISSISSIPPI TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound	The MS Division of Medicaid waiver providers will provide Wraparound services to the participants in the waiver program. Wraparound efforts occur in the community, where services are individualized to meet children's and families' needs. Parents are included in every stage of the process and the approach must be culturally sensitive to the unique racial, ethnic, geographical and social makeup of children and their family. The process of wraparound is designed and implemented on an interagency basis using an interdisciplinary approach in which providers have access to flexible, not-categorical funding. Wraparound services must be delivered on an unconditional basis where the nature of support changes to meet changes in families and their situations. Finally, wraparound involved the measurement of child and family outcomes to determine the effectiveness of services that ensure that appropriate populations are being served. The proposed wraparound services are divided out into two separate categories of service: Wraparound services, licensed skilled professional; and Wraparound services unskilled. The list below, while not an exhaustive list, is a list of the services expected to be provided to participants by wraparound providers as well as the level of skill DOM requires for the service delivered. The list provides for categories and sub listings of service types. Mental Health Services Social Services Educational Services Vocational Services Recreational Services Other Services (e.g. transportation, transitional living)
Functional Assessment	Functional Assessment is a process by which waiver participants are assessed for their current level of functioning by use of identified instruments. As part of the National Evaluation required for this demonstration, MS will use the CANS, the YSS, the YSS-F, the MCSQ, the EQ-R. Assessments will be done subsequent to enrollment, at 6 month intervals and at the time of discharge from the waiver.

MONTANA

MONTANA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	Department of Public Health & Human Services, Health Resources Division	
Operating Agency	Health Resources Division Children's Mental Health Bureau	
Contracted Entities	First Health Services of Montana	First Health Services of Montana will complete Psychiatric Residential Treatment Facility (PRTF) reviews to determine if the individual meets level of care requirements for enrollment in the Waiver program. Preadmission determination involves screening youth to ensure: that the youth meets criteria for Serious Emotional Disturbance; that the youth meets Certificate Of Need requirements for an institutional level of care; meets the criteria for medical necessity; meets the other criteria established for participation in the PRTF Waiver; and resides within an area where operation of the Waiver is in effect. First Health will review clinical information received from community providers based on established protocols for a PRTF level of care. This contractor will also do reevaluations every 12 months, or at the request of the plan manager if significant improvement is noted. .
	Affiliated Computer Services (ACS)	Affiliated Computer Services (ACS) serves as the full fiscal agent for the State's Medicaid program. It will process Medicaid claims and assist Waiver service providers with enrollment.
Local-Regional Non-State public entities	N/A	
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	Health Resources Division/Children's Mental Health Bureau	The Health Resources Division/Children's Mental Health Bureau is responsible for assessing the performance of any contracted entities involved in conducting Waiver administrative and operational functions.

MONTANA TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Home-based Therapist	164,480	411,200	1,127,400	2,254,800	2,254,800	6,212,680
Customized Goods and Services	4,000	10,000	85,000	180,000	180,000	45,900
Consultative Clinical and Therapeutic Services	32,000	80,000	96,000	20,000	20,000	60,800
Education and Support Services	1,500	3,750	7,500	11,250	11,250	35,250
Non-emergency Transportation	1,443	3,608	3,608	7,216	7,216	23,091
Respite Care	66,539	166,347	586,155	1,055,867	1,055,868	2,930,776
Caregiver Peer-to-Peer Support	0	0	256,050	497,875	497,875	1,251,800
Family Support Specialist	0	0	587,750	1,175,500	1,175,500	2,938,750
Wraparound Facilitator	0	0	343,750	687,500	687,500	1,718,750
TOTAL COST	$269,962	$674,905	$3,093,213	$6,070,008	$6,070,009	$16,178,097
Clients Served	20	50	100	200	200	
Cost per participant	$13,498	$13,498	$30,923	$30,350	$30,350	
Average Length of Stay	253	253	253	253	253	

MONTANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Consultative Clinical and Therapeutic Services	Consultative Clinical and Therapeutic Services will assist the youth's physician or midlevel practitioner in developing and carrying out individual treatment/support plans by providing consultations with psychiatrists. This service is specifically designed to provide treating physicians and midlevel practitioners with psychiatric expertise and opportunity for consultation in the areas of diagnosis, treatment, behavior and medication management. Consultative Clinical and Therapeutic Services will be provided by licensed psychiatrists enrolled with the State of Montana as Medicaid providers. Consultation will be provided to a physician or Midlevel Practitioner for a youth enrolled in the PRTF waiver program. A list of psychiatrists participating in the Waiver will be maintained by the plan managers in each county served by the demonstration project. If counties who provide services for the demonstration project do not have the availability of a psychiatrist, a physician can consult with a psychiatrist in another county. Both the consulting psychiatrist and the requesting physician may bill for the consult
Customized Goods and Services	Customized Goods and Services will be available to purchase services/goods not provided by Medicaid. The Customized Goods and Services funds will be utilized for access to supports designed to improve and maintain the youth's opportunities for full membership in the community, socialization and enrichment, as specified by the individual Plan of Care. Use of the Specialized Goods and Services Funds must be related to one or more of the following outcomes: success in school; maintaining the youth in the home; development and maintenance of healthy relationships; prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or becoming or remaining a stable and productive member of the community. Services will help youth alleviate some of the stressors in their living situations, and help them cope with day to day living. Customized Goods and Services funding may NOT be used to provide any otherwise covered services or goods, including (but not limited to) monthly rent or mortgage, food, regular utility charges, household appliances, or items that are for purely diversional/recreational (e.g., televisions or stereos). The Plan Manager and family must attempt to identify alternative funding/resources prior to the approval of Customized Goods and Services funds.
Education and Support Services	Education and support will be provided for unpaid caregivers and treatment team members (e.g., immediate and extended family, teachers, and aides). Instruction on the diagnostic characteristics and treatment regimens (including medication and behavioral management) for the youth will be provided in a group setting. The Education and Support Services have been designed to provide support for families parenting youth with severe emotional disturbance through skill-building in coping skills, dealing with schools, and advocacy. Services will be provided by appropriate community agencies with the capacity to offer specific education and support geared to parents and caretakers of youth with SED. The provider will provide at least two 12-week sessions annually, and will provide materials, space and hand-outs for the sessions.

MONTANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Education and Support Services (continued)	Curriculum will be developed by the provider and approved by the department. The curriculum will be flexible enough that it can be tailored to families requesting information particular to the mental health issues of the youth. Classes will be offered at convenient times and location for parent participation. Education and Support Services may be provided to non-Waiver participants, but payment for this waiver service can only be billed for participants specifically and directly affiliated with a PRTF Waiver participant up to a total of 7 persons per youth. Funding for this service is not already available through other programs such as; IDEA, Rehab Services Act of 1973, or the Schools.
Home-based Therapist	Home-based therapists are licensed mental health professionals who provide face-to-face, individual and family therapy for youth/family in the family home at times convenient for the family and youth. The therapist will guide: the transition process to the PRTF Waiver; the engagement, planning, creation of the crisis plan; and transition from the Waiver services. The home-based therapist: – Assesses, recommends and makes updates to the treatment plan; – Communicates with the Plan Manager regarding to eligibility status, services and treatment; – Develops and writes individual treatment plan with the family; – Reassesses, amends, and updates the individual treatment plan; – Is available to provide crisis response during and after working hours; – Guides the crisis plan development and monitors implementation; – Guides transition of the youth to the community from a PRTF Waiver; – Guides the engagement process by exploring and assessing the strengths and needs of the youth and family; – Attends family and team meetings; – Guides the planning process by informing the team of the family vision; There are two separate units that can be billed for home based therapist services; direct service billing, ($29.00 per 15 minute unit), and billing for attendance at treatment team meetings ($30.00 (per diem).

MONTANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Non-emergency Transportation	Non-emergency Transportation enables participants to gain access to Waiver and other community services, supports, activities and resources specified by the individual service plan. Transportation may be provided for such activities as treatment team meetings, social, recreational and spiritual activities. All non-emergency transportation must be specifically included in the treatment plan and preapproved by the Plan Manager. Participants will be encouraged to access transportation through other sources, and to use non-medical transportation only as a last resort. Non-medical transportation may not be used to transport an individual to school, or for transportation services that are currently provided under the state plan. Non-emergency Transportation is limited to meeting the individual youth's needs, as specified in the individual plan of care. Non- emergency transporters will be employees of the agencies who provide this service. Agencies providing Non-emergency Transportation services must ensure that drivers have appropriate qualifications and valid Montana driver's licenses.
Respite Care	Respite care includes services designed to give a hiatus to the primary caregiver while meeting the safety and daily care needs of the youth. This service is designed to help meet the needs of the youth's caregiver and to reduce the stress generated by the provision of constant care to the individual receiving waiver services. Respite providers are selected in collaboration with the parents. Services are provided by persons (i.e.: agency staff, neighbors or friends), employed and trained by an agency that provides respite care. Respite services are delivered as documented in the individualized plan of care. Respite services can be offered in the youth's home, out of home, or in a licensed facility i.e., youth shelter or group home. Respite may not be provided in a psychiatric residential treatment facility (PRTF), or in a school setting.
Caregiver Peer-to-Peer Support	These services are designed to offer and promote support to the parent/guardian of the youth. A caregiver peer-to-peer support specialist will promote self empowerment of the parent,, enhance community living skills and assist the parent/guardian in developing natural supports. These services are intended to assist the parent/guardian in being able to access appropriate formal and informal services for the youth in the community once discharged from the program. Services may include assisting parent engage successfully with wraparound process and staff; using personal and professional life experiences they may act as a consultant for wraparound staff, to increase their awareness of the difficulties raising a youth with SED thus improving effective parent involvement; they may serve, when requested, as parent representative at a school and other treatment meetings; assist parent in the development of their own advocacy skills; assist with the development of a parent support group.
Family Support Specialist	A family support specialist working under the guidance of the in-home therapist will provide support and interventions to parents and youth. They may assist the therapist in family therapy by helping the parent/child communicate their concerns; provide feedback to therapist about observable family dynamics; help the family and youth implement changes discussed in family therapy and/or parenting classes; may provide education to the parent regarding their child's mental illness; they may coach, support, and encourage new parenting techniques; they can help parents learn new parenting skills specific to meet the needs of their child; and they may participate in family activities to support parents in applying specific and on the spot parenting methods in order to change family dynamics.

MONTANA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound Facilitation	Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry out the wraparound process. The wraparound facilitator meets with the family to help in identifying their strengths and needs, and assists them in developing a wraparound team; assembles the wraparound team; conducts Plan of Care meetings; along with the wraparound team, helps identify needs of youth and family; works with plan manager in identifying providers of services and other community resources to meet family and youth needs and makes necessary referrals; responsible for the documentation and maintenance of all documentation regarding the Plan of Care and the Cost Plan and all revisions to the Plan of Care and/or Cost Plan developed by the Wraparound Team; monitors the implementation of Plan of Care, making sure family and youth are receiving the services identified in the Plan of Care; maintains communication between all team members; and consults with family and other team members to make sure the services the youth and family are receiving continue to meet their needs and assembles the team to make necessary adjustments and revisions.

SOUTH CAROLINA

SOUTH CAROLINA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	South Carolina Department of Health and Human Services (SCDHHS)	DHHS shall approve all operational policies, rules and regulations prior to issuance and implementation. DMH shall submit any proposed policy or procedure changes in writing to DHHS, who shall review and respond in a timely manner. Other waiver related issues should be presented in writing by DMH at the regularly scheduled meetings for discussion and response by DHHS. DHHS is responsible for assuring compliance with Federal standards and regulations to assure health and welfare safeguards, and to ensure that provider standards have been met. DHHS or its designated entity shall review waiver case records on an annual basis and as needed, to determine appropriateness and adequacy of services and to ensure that services furnished are consistent with the nature and severity of the individual's disability.
Operating Agency	South Carolina Department of Mental Health (SCDMH)	The MOA designates that the waiver will be operated by DMH, under the supervision of DHHS. DHHS will exercise administrative discretion in the administration and supervision of the waiver and will be responsible for issuing all policies, rules and regulations related to the waiver. The MOA clearly states that DHHS is the final authority and shall make all final decisions regarding all matters related to the administration of the waiver.
Contracted Entities	Quality Assurance Entity	DHHS contracts with a quality assurance entity as part of the agency's regular reviews of state Medicaid programs. This contractor may be designated, on the behalf of DHHS, to perform reviews of quality assurance issues for waiver functions and outcomes.

SOUTH CAROLINA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
Contracted Entities (continued)	Family Advocacy Organizations	DHHS will contract with Family Advocacy organizations to disseminate and provide information about the waiver, assist families with the enrollment process, assist families with the Fair Hearing and grievance processes, and provide assistance with training. DHHS will contract with Family Advocacy Organizations to: – Disseminate and provide information about the waiver – Assist families with the enrollment process – Attend Service Plan Development meetings with the family – Assist with administering the satisfaction surveys as part of the evaluation process – Assist families with the Fair Hearing and Grievance process. – Provide assistance to the operational entity with training for waiver providers, as needed.
Local-Regional Non-State public entities	N/A	
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	SCDHHS and SCDMH	SCDHHS and SCDMH will jointly share the responsibility.

SOUTH CAROLINA TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Customized Goods and Services	100,000	250,000	280,000	300,000	300,000	1,230,000
Wrap-around Para Professional Services	347,063	1,739,010	1,816,954	1,899,036	1,984,818	7,786,880
Respite	125,438	629,160	657,269	687,582	718,641	2,818,090
Service Plan Development	23,438	119,989	126,095	131,549	137,453	538,522
Peer Support Services	28,688	144,060	149,692	156,006	163,053	641,499
Case Management	129,375	646,470	676,329	705,870	737,550	2,895,594
Diagnostic/Therapeutic Services	486,000	2,429,625	2,537,808	2,663,678	2,783,295	10,900,406
Psychiatric Medical Assessment	24,000	119,130	124,760	131,472	137,400	536,762
Prevocational Services	2,925	14,112	14,453	15,408	16,104	63,002
TOTAL COST	$1,266,925	$6,091,556	$6,383,360	$6,690,600	$6,978,314	$27,410,754
Clients Served	50	125	140	150	50	
Cost per participant	$25,338	$48,732	$45,593	$44,604	$46,522	
Average Length of Stay	152	365	365	365	365	

SOUTH CAROLINA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Case Management	Case management services include: – Assisting participants in gaining access to waiver and non-waiver services as listed on the plan of care. Such services may include medical, social and educational services. Case managers will assist with all services listed, regardless of the funding source (Medicaid reimbursed and Non-Medicaid services) – Educating families about the waiver process and services – Advocating on behalf of families – Coordinating and attending all Service Plan Development meetings – Assisting the family with scheduling and coordinating all appointments – Tracking Service Plan review dates – Monitoring the provision of services included in the participant's Plan of Care – Addressing any grievances or complaints by the family – Tracking/scheduling initial and annual LOC evaluations. Case Managers will also be responsible for furnishing case management services to individuals placed in a PRTF, prior to their transition to the waiver (diversion). Case management transition services can be provided up to 180 consecutive days prior to admission into the waiver. This may also include furnishing services to individuals in institutional settings who will be transitioning to the community in advance of their entrance to the waiver. Billing must be retro-active, after the participant has been discharged from the PRTF, and placed in the waiver.
Prevocational Services	Services that will prepare a participant for paid or unpaid employment. Services will include teaching such concepts as compliance, attendance, task completion, problem solving, improving attention span and safety. Services will not be job-task oriented, but instead, aimed at a generalized result. Services will be included in the participant's plan of care and will be directed to habilitative rather that employment objectives. Prevocational services may be furnished at the provider's program, or in a community-type setting. Appropriate supervision of staff is required. Supervisors will be on-call at all times to assist with emergencies. In addition, supervisors will be available for weekly staffings and meetings to discuss treatment progress and provide guidance/instruction when needed. Transportation between the participant's residence and the educational services site will be provided as a component of the service, and will be included in the rate paid to providers. Documentation will be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1073 of the IDEA (20 U.S.C. 1401 et.seq.).
Respite	Respite services are services provided on a short-term basis to assist the primary caregiver by providing relief from the stress of care giving. Respite services will be billed at a half-hour rate for non-residential and at a per diem rate for residential. The half-hour rates will be utilized when respite is needed on short-term basis in which overnight stays by the waiver participant with the respite provider will not be needed. Per diem rates will be utilized when respite is needed on a longer-term basis in which at least one overnight stay will be needed. The locations where respite care can be provided include the waiver participant's home or a foster home. FFP will not be claimed for room and board.

SOUTH CAROLINA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Customized Goods and Services	Customized Goods and Services will be available to meet the participant's needs that present barriers to participation and success in treatment outcomes. The funds will be used to purchase a variety of one-time or occasional goods and/ or services. The funds may only be used for goods and/or services that are described in the participant's Plan of Care that cannot be purchased by any other funding source. Documentation must be provided indicating the necessity of the expenditure. Examples may include one-time emergency financial assistance for termination of utilities or threat of eviction. Other examples may include clothing, furniture (for transition), school supplies and deposits (for transition). Necessity of the funds must be determined by the Service Plan Development Team, and final approval of the funds will be included as part of overall Plan of Care and budget approval process conducted by the Clinical Care Coordinators (employed by the operating entity). Customized goods and services will not be used to pay for room and board.
Diagnostic/Therapeutic Services	***When the services listed under Diagnostic/Therapeutic Services are added to the State Plan, an amendment will be made to this 1915(c) waiver requesting the services be "extended state plan services". This service category has eight distinct components: Assessment; Individual Therapy; Family Therapy; Group Therapy; Crisis Intervention; Group Therapy for Co-occurring diagnoses; and Medication Monitoring/Wellness Education; and Intensive Family Services. 1) Assessment is face-to-face clinical interactions between a client and a qualified clinician that determines: The nature of the client's problems; Factors contributing to those problems; The client's strengths, abilities and resources to help solve problems; and Diagnoses. The assessment is global in nature and encompasses mental, behavioral, developmental, environmental and physical components. It is the basis upon which the Plan of Care is developed. For waiver enrollment, the assessment will also include interpreting and scoring the CALOCUS. 2) Family Therapy includes interventions with the client's family unit (i.e., immediate or extended family, significant other, legal guardians) with or on behalf of a client to restore, enhance or maintain the functioning and stability of the family unit. 3) Individual Therapy is face-to-face, planned therapeutic interventions. These interventions focus on the enhancement of a client's capacity to, among other things, improve decision-making skills, improve coping skills, and develop improved self-confidence and self-esteem. The depth, extent and duration of treatment through individual therapy will be tailored to the client's specific strengths, treatment issues, needs, diagnosis and functioning level. 4) Group Therapy is intended to assist clients in improving and managing their thoughts, emotions and behaviors. Group therapy assists clients in changing behavior patterns and learning how to cope with stressors in their lives. 5) Crisis Intervention is intensive therapeutic intervention provided by a qualified, enrolled clinician. Interventions will be aimed at stabilizing specific occurrences of child/family crises as they arise or when a child is at imminent risk of harm to self or others, psychiatric hospitalization, or more restrictive placement. Crisis intervention must be provided on a 24-hour, 7 day a week basis.

SOUTH CAROLINA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Diagnostic/Therapeutic Services (continued)	6) Group Therapy for Co-occurring Diagnoses is intended to assist clients in improving and managing their recovery process, while working through the primary issues. It will utilize peer interaction and support. Typically, group members will be at different stages in recovery. This will assist with peer support, while the Certified Addictions Counselors will focus on the use of specific therapeutic modalities. 7) Medication Monitoring and Wellness Education services offer a variety of face-to-face or telephonic interventions to a waiver participant. Such services include: – Assess the need for participants to see a physician. – Determine the overt physiological effects related to medications. – Determine psychological effects of medications. – Monitor participant's compliance with prescription directions. – Educate participants as to the dosage, frequency, type, benefits, actions, and potential adverse effects of the prescribed medications. – Promote health education regarding coexisting conditions that affect psychiatric symptomatology and functioning and promote participant competence. This includes education about psychiatric medications and concurrent substance use in accordance with national practice guideline standards. – Evaluate and determine the nutritional status of participants in support of improved treatment outcomes. 8) Intensive Family Services (IFS) are designed to utilize evidence-based interventions that assist youths with problem behaviors. IFS are pragmatic and goal-oriented treatment interventions that specifically target each factor in the youth's social network that contributes to his or her behaviors. Thus, IFS interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with pro-social peers, improve youth school or vocational performance, engage youth in pro-social recreational outlets, and develop an indigenous support network of extended family, neighbors and friends. IFS assists caregivers in achieving and maintaining techniques used to facilitate these gains by integrating those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies. Intensive Family Services are delivered in the natural environment (home, foster home, school, community). Treatment decisions are decided in collaboration with family members and are, therefore, family driven rather than therapist driven. The goal of IFS is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources, which promotes health. The typical duration of IFS is approximately 4 months, with multiple therapist-family contacts occurring each week. Clinicians rendering IFS will not have caseloads that exceed five child/family units. IFS therapists will be available on a 24 hour/day and 7 day/week basis, to provide services when needed and to respond to crises. IFS are proactive, and plans are developed to prevent or mitigate crises.

SOUTH CAROLINA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Peer Support Services	Peer Support Services is comprised of two categories: Caregiver Peer Support and Youth Peer Support. These services will be provided by individuals or family members who: – Either are or have been consumers of the behavioral health system – Are not direct consumers, but have experience raising a child with SED and has knowledge of the behavioral health system in the state. These services include: providing education and information on the waiver processes, assistance with the entry process to the waiver, assistance with developing the plan of care, identifying needs and establishing priorities, accessing supports, partnering with professionals, overcoming service barriers, providing education and support concerning how to cope with stressors of the youth's disability, assisting with consumer complaints and assisting with the waiver mediation and grievance processes.
Psychiatric Medical Assessment	***When Psychiatric Medical Assessment is added to the State Plan, an amendment will be made to this 1915(c) waiver requesting the service be an "extended state plan service". Psychiatric Medical Assessment (PMA) is a face-to-face, clinical interaction between a participant and a physician or advanced practice nurse to assess and monitor the participant's psychiatric and/or physiological status for one or more of the following purposes: 1) Assess mental status and provide a psychiatric diagnostic evaluation, including the evaluation of concurrent substance use disorders. 2) Provide specialized medical, psychiatric, and/or substance use disorder assessments, as needed. 3) Assess the appropriateness of initiating or continuing the use of medications, including medications treating concurrent substance use disorders. 4) Assess or monitor a participant's status in relation to treatment. 5) Assess the need for a referral to another health care, substance use and/or social service provider.
Service Plan Development	Service Plan Development is a meeting with the family, youth and all other concerned parties in attendance, to discuss and develop a Plan of Care (POC). It will be family centered and family driven. The POC will identify strengths, goals, objectives, and issues that need to be addressed. Specific tasks will be developed, along with who will be responsible for those tasks (family member, public entity, private entity). The POC will also include a detailed crisis plan and a budget. The plan will be approved by the family. Subsequent Service Plan Development meetings can be held at any time, but must be held within 90 day intervals from the date of the first meeting.

SOUTH CAROLINA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound Para-Professional Services	***The service listed in this category will be included in the State Plan, currently under revision and review. Wrap Around services are defined as an array of community-based services designed to help stabilize, maintain and strengthen the functioning level of seriously emotionally disturbed children. Without the provision of these services, the child may be at risk of placement in a more restrictive setting. Wraparound Para-Professional Services include: Behavioral Intervention, Caregiver Services, Independent Living Skills and Community Support Services. These services can be provided in the home, community or the provider's office. Appropriate supervision of wraparound facilitators will be required. Supervisors will be on-call at all times to assist with emergencies. In addition, supervisors will be available for weekly staffings and meetings to discuss treatment progress and provide guidance/instruction when needed. Behavioral Intervention (BI): Interventions designed to optimize a child's emotional and behavioral functioning in the community. BI will be employed to analyze the dysfunctional behavior and design specific techniques to reduce or eliminate undesired behaviors. Specific strategies will be used to change, control or manage adverse behavior. BI will be rendered one-on-one. Only face-to-face contact time will be billed. The primary focus of BI will be to assist the child in restructuring his/her milieu so that more positive treatment outcomes can be realized. Treatment will center on the child's emotional/developmental needs, not solely on preventing disciplinary issues or avoiding consequences. The services provides a child with the opportunity to alter existing behaviors, acquire new more appropriate behaviors, and function more effectively within his or her environment. This is accomplished through a one-on-one relationship between the child and the Behavioral Interventionist, as they participate in a variety of structured therapeutic activities. Examples of some appropriate interventions and/or treatment strategies may include: Shaping, Extinction, Redirection and Positive Reinforcement. Independent Living Skills: Individualized instruction and supportive services provided in the community for youth who are transitioning into independent living. This service is designed to assist participants with developing and restoring skills necessary to operate independently in the community. Examples include budgeting, time management, problem-solving skills, prioritizing skills, communication and socialization skills, interviewing skills, food planning and preparation, how to access community resources and maintenance of living environment. Caregiver Service: Face-to-face instructions with the primary caregiver(s) to enable them to serve as the primary treatment agent in the delivery of appropriate interventions for their child. Formal and informal instruction will be utilized for the purpose of enabling the caregiver to better understand the needs/limits of the child. These services will only be provided to the caregiver and directed exclusively to the treatment needs of the child.

SOUTH CAROLINA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Wraparound Para-Professional Services (continued)	Community Support Service: The intent of this service component is to allow for services rendered after school hours or in a summer camp setting. The emphasis will be on a strong therapeutic component, in a structured environment, with treatment interventions integrated throughout the service time period. Interventions will be designed to meet the goals in the child's plan of care. Treatment must be related to the improvement and/or maintenance of the child's level of functioning. Staff providing Community Support Services will be physically available on-site at all times during program hours. At least one supervisor level staff will be available on-site at all times during program hours. If the treatment setting meets the requirement for licensing by a state regulatory agency (DSS), it must be licensed appropriately. Customized Goods and Services: Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the plan of care. Goods and services provided under this category will: decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; and the participant or the participant's family does not have the funds to purchase the item or service, or the item or service is not available through another source. The need for these goods and/or services will be documented in the plan of care. Experimental or prohibited treatments, services or goods are excluded. Wraparound customized goods and services will not be used to pay for room and board.

VIRGINIA

VIRGINIA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
State Line of Authority	Maternal & Child Health Division within the Medicaid Agency (Department of Medical Assistance Services): specifically, the Specialized Services Unit	
Operating Agency	Maternal & Child Health Division within the Medicaid Agency (Department of Medical Assistance Services): specifically, the Specialized Services Unit	DMAS is collaborating with parents, advocates, and other state agencies (Department Behavioral Health and Developmental Services (DBHDS) and the Office of Comprehensive Services (OCS) with the development, implementation and operation of this waiver.
Contracted Entities	KePRO	KePRO will perform prior authorization for waiver services as of May 1, 2008. KePRO will review plans of care and determine if the identified services adequately meet the needs of participants and DMAS guidelines. DMAS will assume this role until May 1, 2008.
	Optimal Solutions Group (Optimal)	Optimal will conduct a five-year, independent evaluation for Virginia Medicaid's Children's Mental Health Program. The purpose of this study is to evaluate whether children who transition out of residential care and receive community-based services through the CMH Program experience changes in their functional levels over time. The observed changes in functional levels will be compared to changes in functional levels for a comparable group of children who remain in residential care. The study will also measure fidelity by evaluating whether the CMH Program was implemented as intended, to identify whether the implementation of the program—rather than the program itself—may affect observed outcomes. Preliminary results will be available in the second year of the evaluation.
	Public Partnerships Limited (PPL),	Public Partnerships Limited (PPL) provides fiscal management services for consumer-direction.
	First Health Services	First Health Services to complete provider enrollment and management of the Virginia MMIS.

VIRGINIA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
Local-Regional Non-State public entities	Family Assessment and Planning Teams (FAPT) or their designee (a member of the FAPT)	Local Comprehensive Services Act (CSA) Family Assessment and Planning Teams (FAPT) or their designee (a member of the FAPT) will provide transition coordination services for identified waiver participants. The interagency agreement between the local FAPT and DMAS specifies each agency's responsibilities during the transition of the participant to the community.
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	Department of Medical Assistance Services (DMAS)	Prior to contracting with any local or regional state or non-state agency, DMAS first determines if the potential contractor is able to perform the tasks. DMAS has done this with PPL, KePRO, and First Health by issuance of a Request for Proposals. DMAS' work with CSA has provided the confidence that CSA is fully capable of performing the Transition Coordination services. DMAS' relies on the Interagency Agreement to outline the duties that CSA will perform. All responsibilities are clearly defined prior to services being rendered. DMAS will monitor the performance of the local CSA Transition Coordinator by reviewing the documented contacts, the participant's assessment and the appropriateness of the identified services. This will occur during requests for authorization of transition coordination services.

VIRGINIA TABLE 1: DEMONSTRATION GRANT WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	**ORGANIZATION**	**ROLE**
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities (continued)		Virginia DMAS is responsible for the assessment of performance of all contracted entities that take part in waiver operational and/or administrative functions. Medicaid agency employees are assigned the duties of contract monitor to oversee and ensure the performance of the contracted entities and complete an evaluation every six months. Contract monitors are responsible for: 1) Coordinating and overseeing the day-to-day delivery of services under the contract, including assurance that information about the waiver is given to potential enrollees; that individuals are assisted with waiver; 2) Completing and submitting a semi-annual report to the DMAS Contract Officer; 3) Reporting any delivery failures or performance problems to the DMAS Contract Officer; and 4) Ensuring that the contract terms and conditions are not extended, increased, or modified without proper authorization. The evaluation measures include: 1) Has the contractor/agency complied with all terms and conditions of the contract/agreement during the period of this evaluation? 2) Have deliverables required by the contract/interagency agreement been delivered timely? 3) Has the quality of services required by the contract/interagency agreement been satisfactory during the evaluation period? 4) Are there any issues or problems you wish to bring to management's attention at this time? 5) Do you need assistance in handling any issues or problems associated with the contract/interagency agreement? 6) From an overall standpoint, are you satisfied with the contractor's/agency's performance?

VIRGINIA TABLE 2: PLANNED ANNUAL BUDGET AND ENROLLMENT FIGURES						
	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Demonstration waiver Service/Component Cost						
Transition Coordination	132,000	79,200	79,200	79,200	19,800	389,400
Companion Services	654,971	1,957,164	1,957,164	1,957,164	489,603	7,016,068
Environmental Modifications	37,230	111,690	111,690	111,690	27,923	400,223
In-Home Residential Supports	691,971	2,075,913	2,075,913	2,075,913	519,872	7,439,582
Services Facilitation	16,704	55,680	55,680	55,680	13,920	197,664
Family/Caregiver Training	243,672	731,016	731,016	731,016	179,942	2,616,662
Respite	330,826	988,367	988,367	988,367	247,831	3,543,759
Therapeutic Consultation	286,676	860,028	860,028	860,028	211,699	3,078,459
TOTAL COST	$2,394,050	$6,859,059	$6,859,059	$6,859,059	$1,710,590	$24,681,817
Clients Served	100	300	300	300	300	
Cost per participant	$23,941	$22,864	$ 22,864	$22,894	$5,702	
Average Length of Stay	166	166	166	166	166	

VIRGINIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Respite	Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those primary unpaid caregivers who normally provide care. Respite care services may be provided in the individual's home or place of residence or a licensed respite facility (such as a group home or Foster Care Home), however FFP is not claimed for the cost of room and board if respite services are delivered in the home/place of residence. This service will be available through both a consumer-directed and agency-directed delivery approach. Individuals are afforded the opportunity to act as the employer in the self-direction of respite care services for the CMH Waiver. This involves hiring, training, supervision, and termination of self-directed care assistants. Recipients choosing to receive services through the CD model may do so by choosing a Consumer-directed Service Facilitator (CDSF) to provide the training and guidance needed to be an employer. If the recipient is unable to independently manage his/her own CD services, or if the recipient is under 18 years of age, a spouse, guardian, adult child, or parent of a minor child must serve as the employer on behalf of the recipient. The case manager is responsible for coordinating the plan of care development between and among service providers. This includes a holistic review of all of the waiver participant's needs extending beyond those covered by the CMH Waiver. The CDSF, in coordination with the case manager and the individual, coordinates care activities for those individuals electing self-direction of services.
Service Facilitation	Service/function that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing, and managing their own waiver services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the participant/family to be the employer. Practical skills training is offered to enable families and participants to independently direct and manage their waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.
Companion Services	Companion services are assistance with skill development and with understanding family interaction, behavioral interventions for support and safety, non-medical care, non-medical transportation, community integration, and rewarding appropriate behaviors. This service is available through both a consumer-directed (CD) and agency-directed delivery approach and shall not exceed eight hours in one day.

VIRGINIA TABLE 3: SERVICES	
SERVICE	**DESCRIPTION**
Environmental Modifications (Home Accessibility Adaptations)	Environmental modifications are physical adaptations to a client's home or primary place of residence or primary vehicle, which provide direct medical or remedial benefit to the client. These adaptations are necessary to ensure the health, welfare, and safety of the client, or enable the client to function with greater independence in the home. Without these adaptations, the client would require institutionalization in a psychiatric residential treatment facility (PRTF). Such adaptations include the installation of monitoring systems or special locks to ensure the child/adolescent's safety.
Family/Caregiver Training (Training and Counseling Services for Unpaid Caregivers)	Training and counseling services for individuals who provide unpaid support, training, companionship, or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. Family/Caregiver training are training and counseling services provided to families or caregivers of clients receiving services in the CMH Waiver. Training includes instruction about treatment regimens and behavioral plans specified in the Individual Service Plan (ISP), and shall include updates as necessary to safely maintain the client at home. Counseling may be provided to the family/caregiver to improve and develop the family's/caregiver's skills in dealing with life circumstances of parenting a child with special needs and help the client remain at home. All training/counseling will be provided on a face-to-face basis.
In-Home Residential Supports	In-Home Residential Support Services (Residential Habilitation) are agency-directed services which increase or maintain personal self-sufficiency, and facilitate the child and family's achievement of community inclusion and remaining in the home. The supports may be provided in the participant's residence or in community settings. Community living supports provides assistance to the family in the care of their child, while facilitating the child's independence and integration into the community. The service also includes communication and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the client enabling the client to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.
Therapeutic Consultation (Clinical and Therapeutic Services)	Clinical and therapeutic services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, that are not covered by the Medicaid State Plan, and that are necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by licensed professionals in mental health and behavior management. The service may include assessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.
Transition Coordination	Community transition services means intensive services that are provided to individuals who are leaving the PRTF and have chosen to receive services in the community. Community transition services include assessment of the child and family; assistance with meeting the requirements of waiver enrollment; referral for Medicaid eligibility; developing a community plan of care in coordination with the family, CSA (if involved), and other involved parties; identifying community service providers; and monitoring the initial transition to the community. This service is more intense than routine case management but does not occur simultaneously with case management. Transition coordination ends and then case management is initiated.