

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

Implementation Status Report as of October 1, 2008

Final

December 3, 2008

Submitted to:

Effie George, PhD
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
Division of Advocacy & Special Initiatives

Prepared by:



IMPAQ International, LLC
10420 Little Patuxent Parkway, Suite 300
Columbia, MD 21044
Phone: (443) 367-0088
Fax: (443) 367-0477
On the web: www.impaqint.com



Westat, Inc.
1650 Research Boulevard
Rockville, MD 20850
Phone: (301) 251-1500
Fax: (301) 610-4820
On the web: www.westat.com

Contract Number:

HHSM-500-2006-00007I, Task Order # 2

Community-Based Alternatives to Psychiatric Residential Treatment Facilities

Implementation Status Report

December 2008

<u>Section</u>		<u>Page</u>
I	Background and Introduction	1
II	Planned Demonstration Waiver Administration, Services, Funding, and Enrollment, by State	5
	Alaska	6
	Georgia.....	15
	Indiana.....	25
	Kansas	35
	Maryland	43
	Mississippi.....	53
	Montana	58
	South Carolina.....	64
	Virginia	74
III	Cross State Implementation Status Summary	81
	Current Status Table.....	81
	Narrative Summary of Successes, Barriers to Success, and Lessons Learned	83

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 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 waiver program as well as its evaluation. Section II provides an overview of the Demonstration waiver program plans for each of the nine States, as described in their approved Demonstration waivers. Section III provides a cross State comparison table and discusses some of the successes, barriers to success, and lessons learned by the nine States during the planning and beginning implementation stages of their Demonstration waiver programs.

Background

The New Freedom Initiative (NFI) was announced on February 1, 2001, as part of a nationwide effort to remove barriers to community living for people with disabilities. It represents an important step towards ensuring that all Americans have the opportunity to learn and develop skills, engage in productive work, and choose where to live and participate in community life.

The New Freedom Commission on Mental Health (the Commission), created on April 29, 2002, as part of the NFI, 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 problems associated with providing community-based alternatives to children and youth with serious emotional disturbances. 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 not available children and youth are often placed in out-of-State facilities.

The Commission's final report sought to help remedy these problems by specifically recommending that a demonstration be conducted in order to allow The Centers for Medicare & Medicaid Services (CMS) to develop reliable cost and utilization data to evaluate the impact of Medicaid Demonstration waiver services on the effectiveness of community placements for children and

youth with serious emotional disturbances in Psychiatric Residential Treatment Facilities (PRTF). Systems of care and wraparound are specifically cited as effective community-based models that can help 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 are 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 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 service waiver authority to children and youth eligible for the PRTF level of care, so children and youth could stay with their families and receive services in their home communities.

Legislative History of the Demonstration Program

The competitive Demonstration grant program for Community-based Alternatives to Psychiatric Residential Treatment Facilities was created by section 6063 of the Deficit Reduction Act of 2005 (P.L. 109-171). The Demonstration allows up to 10 States (as defined for purposes of title XIX of the Social Security Act) to test the cost effectiveness of providing coverage for home and community based service alternatives for children enrolled in the Medicaid program as they compare to the cost of care in a PRTF.

The purpose of the Demonstration is to:

- test the effectiveness of the program in improving or maintaining a child or youth functional level;
- test the cost effectiveness of providing coverage of home and community based service alternatives to psychiatric residential treatment for children and youth enrolled in the Medicaid program under of title XIX of such 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 are 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 may target children and youth who are not otherwise eligible for any Medicaid-funded, community-based services or supports. At the conclusion of the Demonstration 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.

During the five year PRTF Demonstration, CMS anticipates awarding each State applicant between \$15 and \$50 million. CMS reviewed and approved each State's Implementation Plan (1915c waiver application) prior to allowing States to access funds for Federal reimbursement of services under this grant. Section 6063 also provides an additional \$1 million for a National Demonstration Evaluation.

Grant Awards

Ten States received PRTF Demonstration Grant awards: 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 as CMS uses for all other such waivers. Participating States are required to provide State matching funds. Florida's legislature has not approved State matching funds. As of October 2008, Florida's application remains in abeyance. The remaining 9 States have approved 1915c PRTF waivers. States receiving grants estimate that potentially 10,000 children and youth with serious mental illnesses will benefit from the new programs these grants will fund.

Services

Frequently cited community services to be furnished under the Demonstration include respite care (all States), family services (7 States), wraparound (6 States), customized goods and services (5 States) and employment related services (6 States). Consultative clinical and therapeutic services, skills training, and transition services are included by 4 States.

Among the other services being offered by States are: non-medical transportation, case management, crisis services and mentoring. Habilitation, peer support and personal care services will also be

offered in a few States. In addition to direct services, aspects of wraparound (facilitation, child and family teams and flexible funding) will be provided by 3 States.

Evaluation

CMS is conducting an evaluation of the Demonstration program and will produce interim and final reports based on the results of the evaluation by analyses of data obtained from States participating in the grant demonstration program. CMS will collect and analyze individual-level information as well as aggregate financial data from participating States.

The overall evaluation will directly address 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) which will allow access to individually identifiable functional assessment data for purposes of project specific analyses and to the extent possible project-to-project comparisons. State grantees will acquire approved functional outcomes across the following life domains: community living, school functioning, juvenile justice, family functioning, alcohol and other drug use, mental health, program satisfaction, and demographic variables. States will use 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, at least six month intervals during Demonstration participation, and 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 will also provide aggregated financial information about the costs associated with provision of Demonstration services. IMPAQ and Westat will work with CMS to access and utilize aggregate financial data submitted by States to assess the cost effectiveness of the Demonstration program.

Section II. Planned Demonstration Waiver Administration, Services, Funding, and Enrollment, by State

The tables that comprise this section provide individual summaries of each State have planned approach to Demonstration waiver administration, services, funding and enrollment. The content of these tables was extracted from approved Demonstration waivers. **Any planned changes that may be in pending or planned Demonstration waiver amendments are not reflected here.** Actual numbers and costs are also not reflected here. For each State, there are three tables:

Table 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

This table provides information on the management and oversight of the Demonstration 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 waiver services and the projected costs for each service, projected total cost, projected number of clients to be served, projected cost per client, administrative cost for year one, and the anticipated average length of stay.

Table 3: SERVICES

Services provided by the State as part of the Demonstration waiver program appear in this table, along with a description of each service.

The tables provide a snapshot of the Demonstration waiver program in each State, and demonstrate the variety of administrative approaches and service delivery methods used across State Demonstration waiver programs, as well as the related costs. The tables also provide helpful detail that serves as important context for the materials that will follow in Section III of this report.

ALASKA

ALASKA TABLE 1: DEMONSTRATION 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 Medicaid and Health Care Services	Operationalizing the Implementation of the demo and paying providers
Contracted Entities	Qualis	QIO-determines LOC
Local-Regional Non-State public entities	N/A	
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	University of Alaska, Anchorage N/A	

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	
Administrative Cost	\$832,896					
Average Length of Stay	244	244	263	293	80	

ALASKA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Day Habilitation	<p>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 that enable the individual to reside in a non-institutional setting, such as personal grooming and cleanliness, household chores, eating and the preparation of food. 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.</p> <p>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.</p>
Plan of Care Coordination Services	<p>As the treatment and service planning team leaders, Case Plan Coordination Services intensively support Treatment and Intervention Mentors (TIMs), the youth, family, custodial agency, discharging PTRF, FASD diagnostic team, and all other service plan team members to develop an individualized and integrated service plan. Case 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 child’s progress in functioning, and maintaining fidelity to the “3-M” model are integral parts of this service.</p> <p>Case Plan Coordination Services include clinical oversight of TIM service providers and other paid or unpaid care providers and service plan implementation. They also provide support for therapeutic interventions using a wraparound service delivery approach within the “3-M” model of specific interventions. Case Plan Coordination Services Consultative services also include periodic recipient assessments and monitoring of service plan implementation to document participant progress toward the goals. Consultation, technical assistance for all team members with supervision for TIMs are also integral parts of this service.</p> <p>Specifically, this service definition includes: developing a person-centered, integrated plan of care to identify goals, outcomes, objectives, and issues identified during the intake and needs assessment. Developing the individualized family service plan includes determining activities to be completed by the care plan coordinator 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 plan of care and monitoring its status; and supporting the family to reach the goals of the individualized family service plan while supervising the TIM.</p>

ALASKA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Plan of Care Coordination Services (continued)</p>	<p>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.</p> <p>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.</p> <p>This service is provided by a licensed mental health professional clinician operating within their scope of practice.</p>
<p>Residential Habilitation</p>	<p>This service provides individually tailored supports, using the “3-M” techniques of modeling and mentoring, in a home-like residential setting that enables participants to reach customized goals in their service plans and assist in the acquisition, retention, or 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.</p> <p>Residential habilitation services focus on enabling the participant to attain or maintain the maximum functional level possible. These services are coordinated with all other therapies as specified in the integrated service plan. 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 home, a relative's home, a foster home or group home.</p> <p>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.</p> <p>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.</p>
<p>Respite Hourly Rate</p>	<p>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.</p>

ALASKA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Supported Employment Ongoing Supervision</p>	<p>Definition: All Supported Employment Services consist of intensive, ongoing support that enable participants ages 17-21, 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 at a minimum of 20 hours per week.</p> <p>Specifically, the Supported Employment-Ongoing Supervision service consists of the provision of long-term extended services needed for job maintenance with 20 percent or less intervention by the provider after the Development service has been provided. 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.</p> <p>The recipient's ongoing, extended supported employment plan will include 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. The recipient will report to the employer when he or she is sick and will schedule annual leave according to the employer's policies and procedures and these activities will be monitored by the provider.</p> <p>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 but does not include payment for the supervisory activities rendered as a normal part of the business settings. Co-workers who meet staff qualifications outlined below may be paid by the Ongoing Supervision agency to provide any additional supervision that the waiver recipient may require because of his or her disability.</p> <p>Ongoing Supervision may also include services and supports that will assist recipients in achieving self-employment through the operation of a business. However, 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.</p>

ALASKA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Community Transition Services	<p>Individuals seeking to live independently in the community while using waiver services are faced with many one-time expenses required to set up their own home or apartment in the community. These services provide the set up costs to allow the client to leave the residential living situations while receiving waiver services in the community. Services could include: security deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furnishings and other items essential for basic living outside the residential setting. Services do not include rent, food, recreational or diversional items such as TV, cable service or deposits, VCRs/DVDs, Internet connections or other similar items. Specific services must be detailed and prior authorized in the plan of care and the Treatment and Intervention mentor or the Plan of Care Coordinator will support the recipient in connecting with the actual service provider. Individual providers will bill for services through the qualified home and community based waiver agencies.</p>
Paraprofessional Training and Consultative Services	<p>Professional Training and Consultative services provide instruction and guidance to unpaid caregivers, and natural community supports to facilitate implementation of integrated service plans. By providing instruction on the service plan and “3-M” model, effective interventions outlined in the plan for dually diagnosed youth and how to maintain support within the community, this service helps caregivers carry out individual integrated service plans and become effective mentors and behavioral role models. These services are an integral part of developing an informed, effective, community network of mentors focused on supporting youth through the transition to adulthood.</p> <p>Professional Training and Consultative services are directly related to the caregiver's role in supporting the participant 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 unpaid 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 goals and fidelity to project model.</p> <p>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, and work under the direction of a licensed professional operating within the scope of their practice.</p>
Respite Daily Rate	<p>Daily Respite Care is a service provided outside the recipient's home that may be provided to relieve waiver participants' primary unpaid caregivers. DHSS 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. 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.</p>

ALASKA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Supported Employment Development Services</p>	<p>Supported Employment Development Services include time-limited support services under a place and train model until employment stability is achieved (less than 20 percent intervention by the provider) at which time the individual transitions into the long term extended Supported Employment-Ongoing Supervision 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. Co-workers who meet staff qualifications outlined below may be paid by the supported employment development agency to train the waiver recipient.</p> <p>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. Assistance for self-employment during the development phase may include: (a) aiding the individual to identify potential business opportunities based upon an assessment of his or her individual interests and support needs; (b) development of a written business plan, including potential sources of business financing and other assistance in developing and launching a business; and (c) identification of the disability-specific and business supports that will available to assist the waiver participant in achieving self-employment and the number of hours of service provided per month.</p> <p>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.</p> <p>All Supported Employment Services, both Development and Ongoing Supervision, consist of intensive, supports that enable participants ages 17-21, 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 at a minimum of 20 hours per week.</p>

ALASKA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Treatment and Intervention Mentor Services</p>	<p>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. TIM services monitor and implement the participant's integrated services plan day-to-day and include 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 other 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 clinical oversight of the Care Plan Coordinator.</p> <p>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 then provide the opportunity and support for repetitively practicing these new skills in the community by engaging in the activities with the participant. These habilitation activities expand beyond general habilitation to encompass expanded skills and activities that relate to increased independence and self-sufficiency including:</p> <p>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.</p> <p>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.</p>

ALASKA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Treatment and Intervention Mentor Services (continued)	<p>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.</p> <p>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.</p> <p>TIM service is designed for one provider to serve average caseloads of 3-5, allowing them to provide extensive direct services to participants.</p>

GEORGIA

GEORGIA TABLE 1: DEMONSTRATION 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 Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD)	The DMHDDAD 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, TBD	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	DMHDDAD and the Department of Community Health (DCH)	DMHDDAD 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. DMHDDAD 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	
Administrative Cost	\$950,871					
Average Length of Stay	103	241	239	206	206	

GEORGIA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Care Management	<p>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.</p> <p>Care Management Services include the following components as frequently as necessary or at least on an annual basis:</p> <p>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.</p> <p>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 (DMHDDAD) with oversight by the Medicaid Agency.</p> <p>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.</p>

GEORGIA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Care Management (continued)	<p>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.</p> <p>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 DMHDDAD and at least annually in conjunction with the ISP and any revisions.</p> <p>Care Management Services also assist waiver participants and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment and access to this option. Participants are not required to accept care management as a condition of participating in the Waiver. Those participants/families choosing to assume control of coordinating services for themselves or their family member will need to discuss this option with a regional treatment specialist (non-waiver) who will provide an overview of service access requirements, service planning, service providers and self-direction. A meeting will be held with the Waiver Coordinator to discuss the process to access services and to sign an agreement stating what care management responsibilities will be assumed by the family.</p> <p>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.</p>

GEORGIA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Respite</p>	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> ■ Participant's home or private place of residence ■ The private residence of a respite care provider ■ Foster home ■ Group home <p>The need and plan for Respite Services must be documented in the approved ISP prior to service delivery at least annually.</p>
<p>Supported Employment</p>	<p>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.</p> <p>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.).</p> <p>Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <ol style="list-style-type: none"> 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
<p>Supported Employment (continued)</p>	<p>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.</p> <p>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.</p>
<p>Community Guide</p>	<p>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.</p> <p>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.</p>

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.
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.

GEORGIA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Customized Goods and Services (continued)</p>	<p>Goods and services purchased under this coverage may not circumvent other restrictions of waived 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.</p> <p>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.</p>
<p>Family Training and Supports</p>	<p>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.</p> <p>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.</p>

GEORGIA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Financial Support Services	<p>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.</p>
Transportation	<p>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.</p> <p>Transportation services must be authorized prior to service delivery, and must be authorized in the ISP development and with any ISP revisions.</p>

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 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 will participate 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 will 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 will include at minimum quarterly on-site visits by one or more of the DMHA staff assigned to the project. These on-site visits will include, but not be 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 WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
Contracted Entities	<ul style="list-style-type: none"> ■ Surveillance Utilization Review (SUR) ■ Quality Improvement/Provider Relations ■ Research Assistant ■ Data Manager ■ Grant Evaluator is already consultant for DMHA. ■ IU Center for Survey Research ■ Choices, Inc. (training & WFI) 	<p>SUR Conduct utilization management functions: Waiver auditing will be incorporated into the Surveillance Utilization Review (SUR) functions of a contract negotiated between the Medicaid agency and selected contractor. Implementation is expected to occur during 2008, in the first year of the CA-PRTF grant program.</p> <p>The selected contractor will construct an audit process that utilizes data mining, research, identification of outliers, problem billing patterns, aberrant providers, and those referred by the State. The member's eligibility for waiver services will be validated. Home 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 can provide data to providers to compare against aggregate data. A major focus of the audit exit process will be provider education.</p> <p>Additionally, it is expected that OMPP staff will periodically accompany the contractor on-site, to observe the waiver services.</p> <p>Quality Improvement/Provider Relations Contractor provides training & consultation to Wraparound Facilitators, observes child and family meetings, reviews charts for proper documentation Research Assistant enters data from 6 sources in Access Data base & assists with contact with families and wraparound facilitators.</p> <p>Data Manager will be a new contractor to help with grant operations and evaluation—monitoring grantees, receipt of required information, and running reports.</p>

INDIANA TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
Contracted Entities (continued)		<p>Grant Evaluator (PI) is consultant for DMHA from IU School of Social Work.</p> <p>IU Center for Survey Research collects and manages YSS data.</p> <p>Choices, Inc. provides training to providers and administers WFI.</p>
	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.
	30 Community Mental Health Centers	<p>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:</p> <ul style="list-style-type: none"> - Disseminate information concerning the waiver to potential enrollees; - Assist individuals in waiver enrollment; and - Monitor waiver expenditures against approved levels; and recruit providers.
	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 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 will oversee the contractor's aggregate data to identify common problems, determine benchmarks, and can provide data to providers to compare against aggregate data. A major focus of the audit exit process will be provider education.

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	899,891	971,282	970,255	242,933	3,473,841
Wraparound Technician	595,992	1,376,114	1,485,432	1,483,942	372,652	5,314,131
Habilitation	155,621	360,547	386,099	386,227	96,771	1,385,265
Training and Support for Unpaid Caregivers	73,575	170,625	186,930	186,300	47,520	664,950
Non-Medical Transportation	28,400	64,980	70,740	70,720	17,860	252,700
Flex Funds	175,100	404,600	436,900	436,900	110,500	1,564,000
Respite Total	75,552	169,795	178,100	182,620	48,944	655,011
Wraparound Facilitation/Care Coordination	1,633,000	3,774,559	4,084,369	4,085,749	1,032,240	14,609,916
TOTAL COST	\$3,126,720	\$7,221,112	\$7,799,851	\$7,802,712	\$1,969,419	\$27,919,814
Clients Served	200	321	369	381	264	
Cost per participant	\$15,634	\$22,796	\$21,138	\$20,480	\$7,460	
Administrative Cost	\$441,175					
Average Length of Stay	164	237	223	216	78	

INDIANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Habilitation</p>	<p>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.</p>
<p>Respite</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>Refer to Appendix C-2e for requirements related to the provision of Respite Care by providers who are related to the CA-PRTF participant.</p> <p>Respite is not provided as a substitute for regular child care to allow the parent/guardian to hold a job.</p> <p>Federal financial participation is available for participation in the child/family team meetings.</p>

INDIANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Consultative Clinical and Therapeutic Services</p>	<p>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, 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 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.</p>
<p>Flex Funds</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

INDIANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Non-Medical Transportation</p>	<p>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, to 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.</p> <p>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.</p> <p>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.</p>
<p>Training and Support for Unpaid Caregivers</p>	<p>Training and support services are available 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, co-worker, or companion who provides uncompensated care, training, guidance, companionship, or support to a child/youth served in the CA-PRTF grant. Training includes instruction about treatment and other services included in the Plan of Care (POC) as well as conferences, classes or events in areas such as parent skills-building, child and adolescent development, how to deal with substance abuse, stress reduction, problem solving, communication techniques, advocacy skills, developing community support, building supportive child-parent relationships, monitoring and supervision techniques, positive play and decision making skills. Peer support may be provided to assist the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the participant's POC. Federal financial participation (FFP) is available for the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the POC. FFP is also available as compensation to the providers of this service for participation on the Child and Family Team meetings. FFP is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.</p>

INDIANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Wraparound Facilitation/Care Coordination</p>	<p>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 WF. 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.).</p> <p>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, 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.</p> <p>The Wraparound Facilitator:</p> <ul style="list-style-type: none"> ■ 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; ■ 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.

INDIANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Wraparound Facilitation/Care Coordination (continued)	<p>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.</p>
Wraparound Technician	<p>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.</p> <ul style="list-style-type: none"> ■ 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. <p>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.</p>

KANSAS

KANSAS TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
State Line of Authority	Kansas Health Policy Authority (KHPA)	<p>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.</p> <ul style="list-style-type: none"> ■ 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. <p>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.)</p>

KANSAS TABLE 1: DEMONSTRATION 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 mental health services, including outpatient, clinic option and rehabilitation option services, and Home and Community Based Services under the HCBS-SED waiver and the HCBS PRTF CBA Waiver project. The functions the Contractor will perform are outlined in #7 below.
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. The Community Mental Health Centers subcontract with the Kansas Mental Health PAHP to perform these functions. 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	
Administrative Cost	\$881,248					
Average Length of Stay	270	270	270	270	270	

KANSAS TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Attendant Care</p>	<p>Services provided to a consumer with a serious emotional disturbance who 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.</p> <p>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.</p> <p>Attendant Care does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.</p>
<p>Employment Preparation/Support</p>	<p>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.</p> <p>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.</p> <p>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.</p>

KANSAS TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Employment Preparation/ Support (continued)</p>	<p>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.).</p> <p>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.</p>
<p>Independent Living / Skills Building</p>	<p>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 non covered.</p> <p>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.</p> <p>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.</p> <p>Independent Living /Skills Building does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.</p>

KANSAS TABLE 3: SERVICES

SERVICE	DESCRIPTION
Short Term Respite Care	<p>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.</p> <p>FFP is not claimed for the cost of room & board.</p>
Community Transition Supports	<p>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.</p> <p>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.</p>
Parent Support and Training	<p>Parent Support and Training is a designed to benefit the Medicaid eligible consumer 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 and 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 consumer. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the consumer in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the consumer'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 child's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the consumer with mental illness while living in the community. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the</p>

KANSAS TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Parent Support and Training (continued)</p>	<p>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 child's individualized plan of care.</p> <p>Parent Support and Training does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.</p>
<p>Professional Resource Family Care (Crisis Stabilization)</p>	<p>Professional Resource Family Care (Crisis Stabilization) is intended to provide short-term and intensive supportive resources for the youth 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 youth 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 youth 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 youth, there is regular contact with the family to prepare for the youth's return and his/her ongoing needs as part of the family. It is expected that the youth, family and the professional resource family are integral members of the youth's individual treatment team.</p> <p>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.</p> <p>FFP is not claimed for the cost of room & board.</p> <p>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 recipient at no cost.</p>
<p>Wrap-Around Facilitation</p>	<p>The function of the Wrap-Around Facilitator is to form the wrap-around team consisting of the consumer's family, extended family, and other community members involved with the consumer'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 Wrap-Around Facilitator guides the Plan of Care development process of the team to assure that waiver rules are followed. The Wrap-Around 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 consumer's circumstances warrant changes in the Plan of Care. The Wrap-Around 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 consumer and family/caregivers. Facilitators will be certified after completion of specialized training in the Wrap Around Philosophy, waiver rules and processes, Waiver eligibility and associated paperwork, structure of the consumer and Family Team, and meeting facilitation.</p>

KANSAS TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Wrap-Around Facilitation (continued)</p>	<p>Wrap-Around Facilitation is provided in addition to targeted case management to address the unique needs of waiver clients living in the community and does not duplicate any other Medicaid State Plan Service or services otherwise available to the recipient at no cost.</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

MARYLAND

MARYLAND TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
State Line of Authority	Maryland Department of Health and Mental Hygiene	<p>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.</p>
Operating Agency	Mental Hygiene Administration, DHMH	<p>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.</p> <p>OHS is responsible for monitoring MHA through: 1) Memorandum of Agreement regarding each administration's roles and responsibilities; 2) Quality Management Plan that outlines in detail, quality assurance activities and each entity responsible for that activity; 3) quarterly reports from MHA on reportable events that include trending and tracking of data and plans for remediation; 4) quarterly inter-agency waiver coordination meetings between DWP and MHA to discuss issues, policy, and remediation planning at least on a quarterly basis.</p> <p>As previously Stated, OHS and MHA will develop and implement a Quality Management Plan, which is based upon assuring waiver participant health and safety through appropriate level of care determinations, monitoring and approving plans of care, enrolling qualified providers, monitoring provider performance and providing training, implementing a system for reporting critical events and complaints, and providing administrative oversight and financial accountability.</p>

MARYLAND TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
Operating Agency (continued)		The DWP will assign a waiver coordinator to this waiver, to conduct an annual review a sample of waiver participants' records, which includes a review of that participant's plan of care and issues a report of findings to MHA. If corrective actions are needed, MHA will develop a plan to systematically address each issue.
Contracted Entities	Contracted Project Director	The Project Director will be responsible for overseeing the implementation of the waiver in the 4 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. The Program Director will be responsible to MHA and meet all reporting requirements.
	MAPS-MD	MAPS-MD, the administrative services organization, is contracted by MHA to manage the public mental health system. MAPS-MD determines medical eligibility, pays providers through MMIS, and manages the complaint and appeal process for MHA.
	Core Service Agencies (CSAs) are local public or not-for-profit mental health agencies.	CSAs are involved with determining medical eligibility for the waiver by participating in the independent team review convened by MAPS-MD. Medical, psychiatric, and psychosocial evaluations for medical eligibility are performed by licensed psychologists and physicians and are forwarded to MAPS-MD. MAPS-MD convenes the independent team for the review of the medical, psychiatric, and psychosocial evaluations. The independent team convened by MAPS-MD includes a social worker or similar mental health professional at the local CSA, as well as a MAPS-MD care coordinator, and a MAPS-MD physician. CSAs also disseminate information about the waiver to potential enrollees and assist individuals with waiver enrollment.

MARYLAND TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
Local-Regional Non-State public entities	Core Service Agencies (CSAs) are local public or not-for-profit mental health agencies.	CSAs are involved with determining medical eligibility for the waiver by participating in the independent team review convened by MAPS-MD. Medical, psychiatric, and psychosocial evaluations for medical eligibility are performed by licensed psychologists and physicians and are forwarded to MAPS-MD. MAPS-MD convenes the independent team for the review of the medical, psychiatric, and psychosocial evaluations. The independent team convened by MAPS-MD includes a social worker or similar mental health professional at the local CSA, as well as a MAPS-MD care coordinator, and a MAPS-MD physician. CSAs also disseminate information about the waiver to potential enrollees and assist individuals with waiver enrollment.
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities	MHA	MHA will be responsible for the performance of the contracted project director, MAPS-MD, and CSAs.
	University of Maryland	Performance indicators will be identified and outlined in a contract between MHA and the University of Maryland.

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	469,800	657,720	984,342	1,033,565	3,920,824	7,066,251
Family and Youth Training	422,820	591,948	885,836	930,119	3,528,161	6,358,884
Residential Respite	469,800	657,720	984,342	1,033,565	3,920,824	7,066,251
Mobile Stabilization Support Service	536,355	750,949	1,123,886	1,179,984	4,476,595	8,067,770
Supported Employment	143,516	200,923	300,691	315,728	1,197,719	2,158,577
Peer-to-Peer Support	203,580	285,012	426,600	447,878	1,699,210	3,062,280
Caregiver Peer-to-Peer Support	203,580	285,012	426,600	447,878	1,699,210	3,062,280
Experiential and Expressive Therapies	375,840	526,176	787,450	826,852	3,136,573	5,652,891
TOTAL COST	2,825,291	3,955,460	5,919,746	6,215,568	23,579,118	39,669,893
Clients Served	87	87	124	124	448	
Cost per participant	32,475	45,465,306	47,740	50,126	52,632	
Administrative Cost	\$1,052,316					
Average Length of Stay	233	310	360	360	360	

MARYLAND TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>In-Home Respite</p>	<p>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.</p> <p>*****</p> <p>"Respite care" means services that are:</p> <ol style="list-style-type: none"> (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: <ol style="list-style-type: none"> (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. <p>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:</p> <ol style="list-style-type: none"> (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.
<p>Supported Employment</p>	<p>Supported Employment provides employment support services to individuals for whom competitive employment has not occurred, has been interrupted, or has been intermittent. 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.</p> <p>Supported Employment Services are provided by a Mental Health Vocational Program approved under Maryland Law (COMAR 10.21.28). Supported Employment provides ongoing, time unlimited employment support services to individuals with serious mental illness (SMI) for whom competitive employment has not occurred, has been interrupted, or has been intermittent. 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 (MAPS-MD).</p>

MARYLAND TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Supported Employment (continued)</p>	<p>"Supported employment program" means a program designed to assist an individual to obtain competitive employment in an integrated work environment that provides:</p> <ul style="list-style-type: none"> (a) Compensation to individuals of at least minimum wage; (b) An individualized approach that establishes an hours-per-week employment goal to maximize an individual's vocational potential; (c) Additional supports, as needed, delivered where appropriate; and (d) Transitional employment placements which means a series of planned temporary, sequential job placements, with continuous support services, provided to an individual in the public mental health system until job permanency is achieved. Transitional services are integrated with the youth's IEP when applicable. <p>The SE service, funded under the Public Mental Health System (PMHS), consists of four reimbursable service phases:</p> <ol style="list-style-type: none"> 1) Pre-placement Phase, which includes, at a minimum, MHVP Assessment, referral to the Division of Rehabilitation Services (DORS) and entitlements counseling, and discussion of the risks and benefits of disability disclosure and informed choice. 2) Placement in a Competitive Job (does not include agency-sponsored employment), which includes assisting the consumer in negotiating with the employer a mutually acceptable job offer and advocating for the terms and conditions of employment, to include any reasonable accommodations and adaptations requested by the individual. 3) Intensive Job Coaching Phase (usually reimbursed from DORS), which includes systematic intervention techniques to help the supported employee learn to perform job tasks to the employer's specifications and to learn the interpersonal skills necessary to assume the employee role and to be accepted as an employee worker at the job site and in related community-based settings. Job coaching may also be used as a preventative intervention to assist the individual in preserving the placement, resolving employment crises, and in stabilizing the employment situation for continuing employment. In addition to direct job skills training, job coaching includes related assessment, counseling, advocacy, mobility skills training and other support services as needed to promote job stability and social integration within the employment environment. 4) Extended Support Services Phase, which includes proactive employment advocacy, counseling, and support services at or away from the job site to assist the individual to maintain continuous, uninterrupted competitive employment and to develop an employment-related support system, to include encouraging the use of natural supports, to the maximum extent possible. This service is time unlimited and continues until the individual no longer requests the service.

MARYLAND TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Caregiver Peer-To-Peer Support</p>	<p>Caregiver Peer-To-Peer Support delivered by a Family Support Partner will:</p> <ul style="list-style-type: none"> ■ 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. <p>The following activities are provided to families who request FSO services:</p> <ul style="list-style-type: none"> ■ Assistance in understanding all phases of the Child/Youth Family Team process and in communicating family needs to Care Manager and Team Members. <ul style="list-style-type: none"> – 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
<p>Experiential and Expressive Therapies</p>	<p>Expressive Therapy involves action on the part of the therapist and the consumer and is a subset of Experiential Therapy. This includes understanding of psychotherapeutic systems at both nonverbal and a verbal level as necessary in exploring the developmental properties inherent in the art process. Expressive therapy is a group of techniques that are expressive and creative in nature. The aim of creative therapies is to help consumers find a form of expression beyond words or traditional therapy, such as cognitive or psychotherapy.</p> <p>Expressive therapy includes techniques that can be used for self-expression and personal growth when the client is unable to participate in traditional "talk therapy," or when that approach has become ineffective. Experiential and Expressive Therapies will include:</p> <ul style="list-style-type: none"> ■ Art Therapy ■ Music Therapy ■ Dance/Movement Therapy ■ Psychodrama/Drama Therapy ■ Narrative ■ Writing (Biblio and Poetry) Therapy ■ Photo Therapy ■ Mind/Body Therapy ■ Activity Therapy ■ Recreational Therapy ■ Play Therapy ■ Adventure Therapy ■ Animal Assisted Therapy ■ Horticultural Therapy
<p>Family and Youth Training</p>	<p>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:</p> <ul style="list-style-type: none"> - 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

MARYLAND TABLE 3: SERVICES

SERVICE	DESCRIPTION
Family and Youth Training (continued)	Training normally involves a curriculum or defined set of experiences which will promote usable learning and skill development.
Mobile Stabilization Support Service	<p>Mobile Stabilization Support services are interventions that provide parents/caregivers/guardians with short-term, flexible services that assist in stabilizing children/youth in their home/community setting. Interventions are designed to maintain the child/youth in his/her current living arrangement, to prevent movement from one living arrangement to another and to prevent repeated hospitalizations. Interventions at this level of care include the delivery of a flexible variety of services through the development of a comprehensive and coordinated Individual Crisis Plan (ICP) with entry being part of the youth's POC. This service differs from the State Plan service in terms of its intensity and the type of providers offering services. MSSS will incorporate a team model to include a clinician supervisor and therapeutic aide, who is an individual with a bachelor's degree in a human services field. MSSS providers must meet with the child/youth at least three times per week for the first two weeks of service provision, at least twice each week for the subsequent two weeks of service provision, and at least once a week for the duration of services.</p> <p>Interventions must be coordinated with the youth's primary therapist and may include crisis intervention, counseling, behavioral assistants, in-home therapy, skill building, mentoring, medication management and/or parent/caregiver/guardian stabilization interventions. Mobile stabilization is pre-authorized and reviewed by MAPS-MD. These interventions can be used up to eight weeks. Use of these interventions will vary by setting, intensity and duration.</p>
Peer-To-Peer Support	<p>Peer-To-Peer Support delivered by a Youth Support Partner will:</p> <ul style="list-style-type: none"> ■ 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 ■ Encourage, refer youth to attend peer group and other youth activities throughout planning process ■ Link youth to community resources and a peer network

MARYLAND TABLE 3: SERVICES

SERVICE	DESCRIPTION
Peer-To-Peer Support (continued)	<ul style="list-style-type: none">■ 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
Residential 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. 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 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 Quality Improvement Organization (QIO)	<p>(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 QIO will be responsible for administrative functions on behalf of the Medicaid agency. The QIO will not provide direct services and will not perform assessments or evaluation. Therefore, there is no identified conflict of interest.</p> <p>The 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.</p> <p>The 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 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.</p>

MISSISSIPPI TABLE 1: DEMONSTRATION 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.
	3. Mississippi Families As Allies for Children's Mental Health (MSFAA)	MSFAA will provide and train family support specialist that will encourage and counsel family members. MSFAA will also provide the training and supervision of the Family Support Specialist on their representing the interest of the participating youth and his/her family. This agency will develop, gather and report on family feedback information for the waiver. MSFAA will provide respite services and train community respite providers. MSFAA will provide staff to assist with the evaluation aspects of the waiver.
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	43,191,225.00
Functional Assessment	60,000	100,000	157,500	192,850	289,410	799,760.00
Respite	80,000	200,000	252,000	330,750	347,287	1,210,037.00
Case Management	1,512,000	2,520,000	3,969,000	4,862,025	7,293,060	20,156,085.00
TOTAL COST	4,892,000	8,220,000	12,883,500	15,804,250	23,557,358	65,357,107.50
Clients Served	120	200	300	350	500	
Average Cost per participant	40,767	41,100	42,945	45,155	47,115	
Administrative Cost	\$492,908					
Average Length of Services	270	270	270	270	270	

MISSISSIPPI TABLE 3: SERVICES

SERVICE	DESCRIPTION
Case Management	<p>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.</p> <p>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.</p>
Respite	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The 29 consecutive days and 45 days per fiscal year limit may be met with a combination of PRTF Respite and Acute Psych Respite.</p>

MISSISSIPPI TABLE 3: SERVICES

SERVICE	DESCRIPTION
Functional Assessment	<p>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-MH, the YSS, the YSS-F, the MSCQ (editorial note: name of form has changed to MSSC-RC), the EQ-R. Assessments will be done subsequent to enrollment, at 6 month intervals and at the time of discharge from the waiver.</p>
Wraparound	<p>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.</p> <p>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.</p> <p>Mental Health Services Social Services Educational Services Vocational Services Recreational Services Other Services (e.g. transportation, transitional living)</p>

MONTANA

MONTANA TABLE 1: DEMONSTRATION 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 six 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.
	Bach-Harrison	Bach-Harrison will maintain and report the data for the MDS.
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	822,400	822,400	822,400	3,042,880
Customized Goods and Services	4,000	10,000	20,000	20,000	20,000	74,000
Consultative Clinical and Therapeutic Services	32,000	80,000	160,000	160,000	160,000	592,000
Education and Support Services	1,500	3,750	7,500	7,500	7,500	27,750
Non-emergency Transportation	1,443	3,608	7,216	7,216	7,216	26,699
Respite Care	66,539	166,347	332,694	332,694	332,694	1,230,968
TOTAL COST	269,962	674,905	1,349,810	1,349,810	1,349,810	4,994,297
Clients Served	20	50	100	100	100	
Cost per participant	13,498	13,498	13,498	13,498	13,498	
Administrative Cost	935,407					
Average Length of Stay	253	253	253	253	253	

MONTANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Consultative Clinical and Therapeutic Services</p>	<p>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.</p> <p>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.</p> <p>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.</p>
<p>Customized Goods and Services</p>	<p>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.</p>
<p>Education and Support Services</p>	<p>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.</p> <p>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.</p> <p>Trainers will provide a curriculum specifically designed to instruct caregivers on specific brain disorders such as:</p> <ol style="list-style-type: none"> 1. Hyperactivity Disorder (ADHD)

MONTANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Education and Support Services (continued)	<ol style="list-style-type: none">2. ODD/ Conduct Disorder,3. Borderline Personality Disorder4. Bipolar Disorder/ Depressive Disorder5. Schizophrenia/ Schizoaffective6. Autistic Spectrum Disorders7. Tourette's Syndrome8. Anxiety Disorders9. Reactive Attachment Disorder10. Obsessive- Compulsive Disorder11. Eating Disorders <p>Additionally parents or caregivers will acquire these essential skills and knowledge:</p> <ol style="list-style-type: none">1. Brain Biology2. Communication3. Coping and Self-Care4. Problem Management5. Rehabilitation/ Transition6. Advocacy and Stigma7. Organization/ Record-Keeping8. Types of Therapies9. Juvenile Judicial System10. Medication management <p>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.</p> <p>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.</p>

MONTANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Home-based Therapist	<p>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.</p> <p>The home-based therapist:</p> <ul style="list-style-type: none"> - 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; <p>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).</p>
Non-emergency Transportation	<p>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.</p> <p>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.</p>

MONTANA TABLE 3: SERVICES

SERVICE	DESCRIPTION
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.

SOUTH CAROLINA

SOUTH CAROLINA TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
State Line of Authority	South Carolina Department of Health and Human Services (SCDHHS)	<p>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.</p> <p>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.</p>
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 WAIVER ADMINISTRATION AND OPERATIONS		
RESPONSIBILITY	ORGANIZATION	ROLE
Contracted Entities (continued)	Family Advocacy Organizations	<p>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:</p> <ul style="list-style-type: none"> – 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.
	Evaluation Group	<p>DHHS will contract with the Center for Health Services and Policy Research at the University of South Carolina to determine effectiveness in meeting the goals and objectives of the project. The evaluation will follow a “quality improvement” model, where regular feedback is given to project staff to enable them to improve implementation fidelity, process, and outcomes, and thereby increase the effectiveness of project efforts. The formative evaluation will assess performance over time to rapidly identify and correct problems before they interfere with collaboration, planning, and implementation. The evaluation process enables discussion of problems to take place in constructive context. During FFY 2008-09, evaluation efforts will focus predominantly on monitoring implementation of the demonstration through qualitative methods and on collecting / reporting quantitative data required by CMS’ Minimum Data Set.</p>

SOUTH CAROLINA TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
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	
Administrative Cost	\$342,308					
Average Length of Stay	152	365	365	365	365	

SOUTH CAROLINA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Case Management	<p>Case management services include:</p> <ul style="list-style-type: none"> - 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. <p>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.</p>
Prevocational Services	<p>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 than 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 1973 of the IDEA (20 U.S.C. 1401 et.seq.).</p>
Respite	<p>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.</p>

SOUTH CAROLINA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Customized Goods and Services</p>	<p>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).</p> <p>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).</p> <p>Customized goods and services will not be used to pay for room and board.</p>
<p>Diagnostic/Therapeutic Services</p>	<p>***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”.</p> <p>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.</p> <ol style="list-style-type: none"> 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.

SOUTH CAROLINA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Diagnostic/Therapeutic Services (continued)</p>	<p>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.</p> <p>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.</p> <p>Medication Monitoring and Wellness Education services offer a variety of face-to-face or telephonic interventions to a waiver participant.</p> <p>Such services include:</p> <ul style="list-style-type: none"> - 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. <p>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.</p>

SOUTH CAROLINA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Diagnostic/Therapeutic Services (continued)	<p>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.</p>
Peer Support Services	<p>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:</p> <ul style="list-style-type: none"> - 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. <p>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.</p>
Psychiatric Medical Assessment	<p>***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".</p> <p>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:</p> <ol style="list-style-type: none"> 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	<p>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.</p>

SOUTH CAROLINA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Wraparound Para-Professional Services</p>	<p>***The service listed in this category will be included in the State Plan, currently under revision and review.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

SOUTH CAROLINA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Wraparound Para-Professional Services (continued)</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>Wraparound customized goods and services will not be used to pay for room and board.</p>

VIRGINIA

VIRGINIA TABLE 1: DEMONSTRATION 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 of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) and the 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 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)	<p>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.</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 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 enrollment; that level of care evaluations are

VIRGINIA TABLE 1: DEMONSTRATION WAIVER ADMINISTRATION AND OPERATIONS

RESPONSIBILITY	ORGANIZATION	ROLE
Assessment of Performance of Contracted and/or Local/Regional Non-State Entities (continued)		<p>completed; that waiver requirements are met according to the participant's plan of care; and that prior-authorization is conducted in accordance with review criteria and approved procedures;</p> <ol style="list-style-type: none"> 2. Ensuring that services are delivered in accordance with the contract and that deliverables are in fact delivered; 3. Approving invoices for payment in accordance with the terms of the contract; 4. Completing and submitting a semi-annual report to the DMAS Contract Officer; 5. Reporting any delivery failures or performance problems to the DMAS Contract Officer; and 6. Ensuring that the contract terms and conditions are not extended, increased, or modified without proper authorization. <p>The evaluation measures include:</p> <ol style="list-style-type: none"> 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	
Administrative Cost	82,818					
Average Length of Stay	166	166	166	166	166	

VIRGINIA TABLE 3: SERVICES

SERVICE	DESCRIPTION
Respite	<p>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.</p> <p>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.</p> <p>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.</p>
Service Facilitation	<p>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.</p>
Companion Services	<p>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.</p>

VIRGINIA TABLE 3: SERVICES

SERVICE	DESCRIPTION
<p>Environmental Modifications (Home Accessibility Adaptations)</p>	<p>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.</p>
<p>Family/Caregiver Training (Training and Counseling Services for Unpaid Caregivers)</p>	<p>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.</p>
<p>In-Home Residential Supports</p>	<p>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.</p>
<p>Therapeutic Consultation (Clinical and Therapeutic Services)</p>	<p>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.</p>
<p>Transition Coordination</p>	<p>Community transition services mean 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.</p>

Section III. Cross State Implementation Status Summary

Section III provides a summary table to facilitate cross-State comparison of the current status of waiver programs. The table includes data from approved State waivers as well as available data as of October 1, 2008, as provided by States to CMS and evaluators. Following the table is a narrative section which discusses illustrative successes and challenges in the States' implementation of the waiver programs.

CURRENT STATUS OF STATE DEMONSTRATION WAIVER PROGRAMS¹

	ALASKA	GEORGIA	INDIANA	KANSAS	MARYLAND	MISSISSIPPI	MONTANA	SOUTH CAROLINA	VIRGINIA
Demonstration Waiver Approval Process									
Approval Date	10/01/07	08/07/08	10/04/07	01/01/08	12/27/07	10/01/07	10/01/07	12/20/06	10/31/07
Amendment Approval Date						12/20/07			
Approved Effective Date	10/01/07	09/01/08	10/01/07	4/1/08	01/01/08	11/01/07	10/02/07	01/01/08	12/01/07
Client Enrollment									
Date of First Client Enrollment	12/01/07	N/A	02/5/08	4/13/08	N/A	11/28/07	04/29/08	06/11/08	03/14/08
Number of planned enrollees for Demonstration waiver Year 1	7	37	200	189	50	120	3	50	100
Number of actual enrollees as of October 1, 2008	1	0	118	21	0	99	3	7	4
Number of transfers from PRTFs to date	1	N/A	3	10	N/A	20	2	0	4
Number of diversions to date	0	N/A	115	9	N/A	98	1	7	0

¹ Source: Data collected for CMS reporting purposes by National Evaluator Technical Liaisons and verified by grantee States.

Narrative Summary of Successes, Barriers to Success, and Lessons Learned

All nine States have had their Demonstration waiver applications approved and are currently in various stages of the implementation process. Children and youth in seven States have been enrolled in the Demonstration waiver, with the final two States, Georgia and Maryland, expected to begin enrollment by early 2009. All States have encountered many successes and lessons learned throughout the implementation process. Below are some key implementation issues:

- **Implementation challenges were encountered throughout the entire process.** The planning process prior to Demonstration waiver implementation proved to be a long process for some States. Throughout the planning for Demonstration waiver implementation States have revised State regulations and provided consultation and training to staff and providers at every stage and level. States were involved with coordinating data collection and encouraged collaboration across numerous State agencies. One of the most difficult tasks some States encountered was to reassure and bolster the support of PRTF staff to refer children and youth to the Demonstration waiver because it has meant losing those children and youth as PRTF consumers. States were able to overcome many of the obstacles they encountered by establishing communications protocols, reinforcing working relationships among key stakeholders, developing continuous quality improvement efforts, and trying not to become overwhelmed but work through each problem that arose along the way.
- **Collaboration between the State mental health and Medicaid agencies is critical.** For those States that reported a solid working relationship between State agencies of mental health and Medicaid, most had a long history of collaboration prior to the Demonstration waiver demonstration program. This pre-existing collaboration has been vital to getting the Demonstration waiver operating in a shorter time period. States without a history of close collaboration between these agencies needed a longer planning period to develop a shared understanding and vision for the demonstration as well as to create specific policies and procedures necessary to implement it. Several States reported that one of the biggest challenges to collaboration was both agencies struggling to learn each other's language, policies, and procedures. Most States agreed that the Demonstration waiver program provided an excellent opportunity for mental health and Medicaid agencies to work together to produce beneficial outcomes for beneficiaries.
- **State fiscal crises are likely to impact the Demonstration waiver program.** States anticipate that current fiscal crises could impact the Demonstration waiver programs directly by reducing the amount of State matching funds, which would in turn reduce the number of children and youth served through the program. States also indicated that measures to reduce State agency budgets could also have indirect effects, such as impeding or slowing the process to hire staff and contractors for the Demonstration waiver program and reducing the capacity of local providers in response to receiving less State (and even private) funding for their other services. One Project Director

noted; “As State budgets are cut, (local service) providers will have to reduce their services and this may have impact on their capacity to participate in the waiver program.” Another concern is the potential for a high staff turn-over in State agencies (e.g., due to early retirement buy-outs) and this could impact demonstration staff’s ability to maintain relationships with critical partners.

- **Need to educate providers about the availability and quality of local home and community-based services as a viable alternative to residential treatment.** Shifting psychiatric treatment services for children and youth from institutional settings to home and community-based setting is a fundamental systems change. It will take time not only to build the capacity of local areas to be able to provide home and community-based services (as discussed below), but also to change the perception and the routine way of addressing these issues by sending children and youth to institutional settings. For example, States have reported encountering resistance from psychiatrists who are accustomed to sending children and youth from acute hospital care to PRTFs because they are not aware of, or confident in, the availability of alternative community-based services. States have noted that some providers, and indeed some family members, are reluctant about participating in the Demonstration waiver program due to concerns that the same level of services can be provided outside the residential setting.
- **Need to build the capacity of local providers to provide home and community-based services.** States have focused much of their efforts on building the capacity of local providers to be ready to provide the level of services needed by participating children and youth and families. Provider recruitment continues to be one of the most frequently noted challenges among State Demonstration waiver programs. Only one State reports no challenges with provider recruitment, and that is due to the fact that all of their behavioral health providers are able to provide services to Medicaid enrollees. Another State reported minor challenges in the area of provider recruitment and attributed its success to its pre-existing relationship with two large provider networks that provide care Statewide. States with a pre-existing provider infrastructure based on other grant streams (e.g. SAMHSA System of Care grants) appear to have had an easier time getting their providers in place and have been able to build off these pre-existing networks to cover a larger geographic region with demonstration services.

Those States reporting significant challenges in recruiting providers report that Medicaid provider enrollment in general can be challenging and poses barriers to local service providers. With regard to provider enrollment for the Demonstration waiver program in particular, one State noted that providers have been reluctant to engage with the Demonstration waiver because the policies and procedures have been unclear (e.g., cost limits, a method for billing). Another State notes that cuts in other State funding may result in lowering providers’ capacity which could affect their ability to be qualified for Demonstration waiver services. In some States, there are regions where an existing cadre of providers is already in place and has the capacity to provide home and community-based services, but this capacity does not yet exist State-wide. In these newer regions, States are focusing their current efforts on provider recruitment and training to build the necessary foundation prior to enrolling children and youth for those regions. One State reported that implementation of the wraparound model has

presented some challenges because not all providers are familiar with wraparound model concepts.

- **Successful participant recruitment is dependent on States having existing community-based programs and providers in place.** States reporting successes in participant enrollment noted existing wraparound programs in communities and resulting familiarity of this model among participants, families, and referring providers. In these areas, States have discovered that children and youth and families that are comfortable with community-based care, would advocate for it, and utilize these services. PRTFs were even willing to refer transitioning children and youth to these successful community-based programs. In States without a pre-existing similar program, families have sometimes been reluctant to have their children and youth return home from PRTFs because they were either not ready to have the children/youth back or they were skeptical of the effectiveness of the community-based programs.
- **Preparing for MDS data collection has been challenging.** Several States report that all of the MDS data cannot be collected from a single, existing State database. Most States are relying on a combination of multiple State databases and the creation of separate processes to collect the remaining missing data elements. Specific challenges mentioned by the States include: lack of some data elements for the control group, the need to obtain new signed consent forms authorizing the sharing of data from existing State sources with CMS where this was not covered by previously signed forms, existing data elements that may not quite match the requested MDS data elements, the need to clarify the operationalization of MDS data elements, questionable reliability of some data sources, and the need to revise quality assurance plans in order to ensure quality data collection.
- **Gathering comparison group data is more difficult than anticipated.** While almost all States plan to gather comparison group data at this point, comparison groups seem to have required major effort in several States and decisions about gathering data on these groups are still evolving. Six States with comparison groups report a range of changes from their approved Demonstration waiver and some are anticipating problems in collecting data. One concerned State mentioned an expected increased burden on staff time to gather comparison group data and is now reconsidering having a comparison group. Most States have decided to use children and youth enrolled in PRTFs for their comparison groups. Challenges related to using children and youth in PRTFs as a comparison include the need to develop separate data collections systems and concerns regarding comparability of children and youth in PRTFs and the Demonstration waiver, given the differences in living environment and restrictiveness of care. Another State had initially planned to sample children and youth who were turned down by the Demonstration waiver program as their comparison group, but due to concerns about population participation, the State has changed their plan and will now use children and youth in selected PRTFs.