CMS DEMONSTRATION PROJECT:
COMMUNITY-BASED ALTERNATIVES TO
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES
Week Ending September 29, 2006

Q1. Could you clarify what is required related to the State level of Care Assessment? We are thinking this assessment relates to individuals and that we could provide a list of assessments that we use along with a brief description of how they are being used....Is this the type of information that is being requested??? Another question.....Do we need to specify the cut offs in relation to the assessment (what will qualify & what doesn't) in the grant or can this information be provided with the implementation report?

A1. In Section 2.K., Evaluation, Evaluation data collection, in the second bullet, it states," States may use any of several validated functional assessment tools to measure the functional status of youth in the Demonstration (see Attachment 3 for a Web link to validated tools)."

Attachment 3 gives the following link to review:
http://www.hcbs.org/files/66/3259/SEDBriefIIAssessmentofChildren.pdf

The question remains, are the tools you are using validated tools as described in the link above?
Can you describe how they are validated in your application and provide copies of the assessment tools?
See Part IV Section F, Part 4, B. Variables, "…describe the instruments and provide a copy in the indexed appendix to the application."
The submitted tool/tools will be reviewed by a panel of experts to score your submission against the review criteria. Your Level of care criteria will determine your "cut-offs" as we understand the use of that term. The level of care criteria is a required document to be included in your application.

Q2. We have inpatient level of care criteria and residential treatment program level of care criteria that includes children with SED who would be placed in PRTF's. However, I don't see any mention of "Level of Care" in the published narrative. Can you clarify what was meant by the comment about "Level of Care" being one of the key requirements to determine the eligible population for states to consider in the application?

A2. **In Section, I. B. 6th paragraph as follows**; Services in a PRTF are provided to individuals who are at an **institutional level of care** and such services **must be a benefit under the State plan**. States must ensure that such facilities comply with **Federal statutory and regulatory specifications related to PRTFs at 42 CFR §440.160, § 441.151-152, and §483.352-.376**. States that purchase the PRTF benefit from other State(s) are considered to be operating such a benefit under their State plan and are eligible for participation in this demonstration. As a part of a State's application to this demonstration, the State shall

submit a copy of the pre-print page(s) indicating that such benefit is covered under the State's Medical Assistance Plan.
Please see Additional Information from Sept. 22 Q & A #6 that describes the requirements of Section 6063 of the DRA in relation to the level of care which describes the level of care as an "inpatient setting" meeting specific criteria under **42 CFR §440.160, § 441.151-152, and §483.352-.376.**

Q3. In our state we do not have PRTF's in the state plan nor do we have children in out of state PRTF'S. However, we have children who are in an inpatient hospital and others who are in Residential Treatment Facilities who meet the level of care criteria of clients in PRTF and who could benefit from Home and community based services. If we do not have PRTF's in our state plan, can we still submit an application based on the client population in high-end staff-secure facilities.

A3. **Please see Additional Information from Sept. 22 Q & A #6** that describes the requirements of Section 6063 of the DRA in relation to the level of care which describes the level of care as an "inpatient setting" meeting specific criteria under **42 CFR §440.160, § 441.151-152, and §483.352-.376.**

Q4. **What additional options do we have for covering the costs of establishing the infrastructure needed to implement the Demonstration Project beyond our state's existing authority for Administrative costs under CFR 42 433.15? For example, can we utilize Medicaid funds to pay for the costs of the required evaluation through a contract with an independent evaluation entity, or must we utilize state staff only? How can we utilize Medicaid funds to cover the costs of the required involvement of advocacy and special interest groups?**

A4. Administrative costs under CFR42 433.15 (7) states," All *other activities the Secretary finds necessary for the proper and efficient administration of the State Plan*". Since the administrative costs associated with implementation of the PRTF demonstration will:
(1) be billed against the grantee's total grant award; and
(2) operate under the auspices of a 1915©, but also include additional requirements (such as participation in a national evaluation);
CMS maintains discretion as to what are reimbursable costs under the demonstration. Applicants are expected to submit proposed administrative and service budgets as part of the application and these budgets will serve as upper limits on the initial grant award and expenditures for each applicant under the demonstration. The administrative budgets will be examined by the review panel in making recommendations for award and CMS staff to determine whether the proposed demonstration costs supplant existing state administrative costs, and are excessive based on the applicant's design of the demonstration and evaluation. The regulations regarding administrative costs are cited on page 18 of the solicitation, 2. H, 1. While the administrative and service budgets proposed in the applications will serve as upper spending limits under the demonstration, CMS will work with the grantees during the pre-implementation phase and implementation phases to review their budgets and explore modifications, as necessary. For example, some grantees may not achieve the enrollment anticipated/budgeted for in their applications, thus not have the ability to expend their full grant award. In other instances, a grantee may want to

expand their demonstration beyond what was originally proposed. As such, grantees may request modifications to the upper limits during the life of the demonstration. CMS will review and grant such modifications pending the availability of funds.

Q5. **What existing Medicaid statutory and regulatory requirement governing the administration and operation of a section 1915 (c) waiver program?**

On page 8 of the solicitation CMS states that participating programs shall comply with existing Medicaid and statutory requirements governing the administration and operation of a section 1915© waiver. While there is a statement that 6 statutory assurances are of particular interest, States awarded a demonstration will be required to comply with all ten assurances that are applicable under the demonstration located at 42 CFR 441.302. CMS will work with successful applicants immediately following award to ensure the demonstration Implementation plan adequately addresses the statutory assurances.

Health & Welfare (*demonstration*)**:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver**.** These safeguards include:

As specified in **Appendix C of the Implementation Plan**, adequate standards for all types of providers that provide services under this waiver***;***

Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C of the Implementation Plan**.

Financial Accountability: The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

Evaluation of Need *(demonstration)**:*** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver**.** The procedures for evaluation and reevaluation of level of care are specified in **Appendix B of the Implementation Plan**.

Choice of Alternatives *(demonstration)***:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1.Informed of any feasible alternatives under the waiver; and,
2.Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J in the waiver application and Appendix I for the demonstration Implementation Plan**.

Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

Institutionalization Absent Waiver : The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan which will be determined during the implementation planning phase of the demo.

Habilitation Services: *(demonstration)*. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

Services for Individuals with Chronic Mental Illness: The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services

to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.