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### Community Living Exchange

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Waiver Options Serving  
Children with Mental Health Needs  
Audio Conference Transcript

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**Rutgers Center for State Health Policy**  
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**Marlene A. Walsh and Nirvana Huhtala**

**Children's SED Waiver Conference Call**

Operator: Good afternoon ladies and gentlemen and welcome to the Rutgers Children's SED Waiver Conference Call. At this time all participants are in a listen only mode. A brief question and answer session will follow the formal presentation. It is now my pleasure to introduce your host, Ms. Marlene Walsh of Rutgers. Thank you, you may begin.

Marlene Walsh: Thank you so much Doug. Good afternoon everyone, welcome to this audio-conference on Waivers for Children With Severe Emotional Disturbance. My name is Marlene Walsh and I am the Deputy Director for Technical Assistance at the Community Living Exchange Collaborative at Rutgers Center for State Health Policy. This audio-conference is funded by a grant from the Centers for Medicare and Medicaid Services and has been organized by the Rutgers Center for State Health Policy in collaboration with the National Academy for State Health Policy and the Independent Living Research Utilization.

This audio-conference was organized specifically to meet the needs of Real Choice Systems Change grantees that were funded last year to conduct feasibility studies to support the development of viable community treatment alternatives for children in their states. I would like to first acknowledge our partner from ILRU and co-lead for this grantee group, Darrell Jones. Good afternoon Darrell, glad you can join us today.

Darrell Jones: Thank you so much Marlene, hello everyone. Glad you could be with us.

Marlene Walsh: Before we continue I would also like to thank Nirvana Huhtala, our project assistant at the Rutgers Exchange Collaborative for her outstanding assistance in developing the format and products for this call. Thank you Nirvana.

Finally, I would like to acknowledge and thank Peggy Clark, our Mental Health Policy Advisor and Cathy Cope, our project officer from CMS for helping to make this event possible and for their ongoing support at a critical time in the Real Systems Change effort. Thank you ladies. We will begin our conference today with brief presentations by representatives of the States Vermont, New York, Kansas, Wisconsin and Indiana which are currently administering 1915(c) HCBS waivers for children with chronic mental illness. A draft summary of the waivers accompanied the final conference call announcement last week. I need to emphasize that the summary is a draft document developed to give a simple comparison of the waivers across the five states. The source of the information was taken from the approved waiver documents. Also, we know that we will be presenting a lot of information with five states talking about their waivers on the same call, so we have asked the presenters to focus their remarks in the context of

answering 10 questions when describing their waiver. These questions were also shared with you all in the final call announcement.

We understand that any one of these questions could generate the need for additional audio conferences like this one, or perhaps separate topical calls with one or more grantees. This call today could be the first of many, so please don't feel like we have to get everything in over the next 90 minutes. We hope that the information shared today will spark a discussion that will result in a better understanding of some of the resources that exist today for this target population and most importantly provide assistance to the members of our CTAC work group as they implement their grants. It should be noted that this audio-conference is being recorded. Shortly a text transcript as well as the recording of the conference in its entirety will be available on the hcbs.org website. We will begin the question and answer period after all the presentations are done. So without further delay I would like to introduce our first speaker, from Vermont, John Pierce and his colleagues Todd Bauman and Melinda Tremblay. Thank you John.

John Pierce: Okay, and don't hesitate to interrupt us if we get too far afield or are taking too much time. Todd is going to do most of the heavy lifting today, and I think we will now turn to him to begin talking about the answers to the ten questions.

Todd Bauman: The first question is, describe your waiver. Our waiver became operational in 1982. Currently we're serving, our youngest child we have on a waiver is a five year old, up to 21 year old, male and female both. The average length of time enrolled is roughly 12 months. The average cost per child is roughly \$28,000.00 per year. We serve about 250 kids per year on our waiver.

The SED services that we offer, we really emphasize community integration, and if a child cannot remain in their own home, we at least try and keep them in a therapeutic foster home with a lot of family involvement, try and keep them in their own community, we offer a lot of respite, crisis support, clinical services such as psychiatry, individual therapy, family therapy, case management, community integration.

Which ones are the most effective? In general we found that the more active the family is in treatment the more likely the child is to internalize those gains and make long term success, so again any chance we have to keep kids in their home or at least local, and pull the families into treatment we find that that works best.

How do we monitor progress? We have a system where we used the CBCL, the Child Behavior Checklist, and that is completed as part of the waiver application. We use that as a baseline and then gauging progress going forward.

The quality indicator? Again we use the CBCL to gauge quality of clinical services. We also have a satisfaction survey that we give to parents, families, community providers, community partners in regards to kids being served on waivers. And again, how are family and caregivers involved in care plans? I would say any way we can pull them in. We definitely try and pull them in any chance we get, and we have a law, it's called the Act 264 law, which requires family involvement where appropriate for kids with SED. It's part of our system of care.

John Pierce: Sounds good. I'll go and say a few words about the history. The program started, Todd was 13 years old when we started our waiver.

Todd Bauman: I wasn't on a waiver though.

John Pierce: I was older than that, and I remember that we had a youth treatment unit at our state hospital of about 20 beds, and what we were really looking to do is to figure out a way to close that youth treatment unit and replace it with community services. That was really the thinking around our waiver. That was in the very early days of the existence of the home and community based waiver, and we were at the same time applying for a waiver for developmental services and at one point we actually had a combined waiver that included the SED population along with developmental services, but now it is its own unique separate waiver. And now I'll turn back to Todd on challenges for implementation.

Todd Bauman: Some of the challenges that we experienced are around rate setting, and setting rates for specific waiver services. We -- and this goes in with number seven a little bit as well, about lessons learned -- roughly 75% of the waivers, the business we do is with other people's money, so we're really good at pulling in community partners via our child protection, child welfare, that's our largest partner, and because we're so good at pulling in other people's monies, at times that makes for real complicated billing. That's one of the challenges I think that we're constantly struggling with.

Estimated costs? Again the average waiver is roughly \$150.00 a day, and just to compare that to our hospital bed, or hospital, here in Vermont it's \$1,200.00 a day. We don't have waiver slots, that's a question that we get asked quite a bit. We don't have a certain number of slots, but we have a total waiver budget that we manage to. So for example we can have two kids on a \$150.00 a day waiver, or we can have one kid on a \$300.00 a day waiver, and again, we manage to the bottom line of dollars as opposed to slots.

Adequacy of the system of care? We think of the waiver as supplementing the overall system of care that we have. Our system of care still covers the basic needs of kids with mental health issues, yet again case management, psychiatry, therapy and the waiver we view as sitting on top of that as supplementing our system of care. The waiver is not our system of care it's not designed to replace the system of care for kids.

Methodology used to justify cost neutrality? Again we look at the average cost of a daily waiver and compare that to our average cost of our hospitalization which is roughly \$150.00 a day per waiver and \$1,200 a day for the hospital in-patient.

Lessons learned? It's one of our biggest challenges again, but using other people's money is a great thing if you can partner with other people and stretch those dollars farther, it can really build a sense of, again it strengthens the system of care and a sense of they're not your kid or my kid, but they're all of our kids and we're all in this together and we've gotten pretty good about mixing up the money to help make that happen.

How does the medicaid waiver fit into the system of care? Again, it's designed to supplement the system of care it's not designed to replace the system of care.

Cross-agency collaboration? Again, 75% of the dollars that we spend on waivers are other people's money. You have state-funded programs for SED kids who are not Medicaid beneficiaries, those are pretty limited. We do have a mechanism to pay for room and board, if a child's on a waiver receiving waiver services, we can use state general fund to help cover the room and board cost, or to cover all the room and board costs of a child placed out of the home, but we don't have any specific programs at a state level designed to serve kids who are not Medicaid eligible.

John Pierce: And I would just say another word about question number eight, how does the Medicaid waiver fit into the system of care. We do not look at the waiver as a program, we look at it as a funding source, and as such it really represents a very small portion of the total funding available for children's services, and so we really just try to use it strategically to fund those situations that are not fundable by say Medicaid fee for service, or the family themselves or private insurance. We should also say that under Vermont's Medicaid eligibility rules virtually all children, except those who are really very wealthy are eligible for Medicaid so the issue of people working with kids who are not Medicaid eligible really doesn't come up very often, and I think we're done.

Marlene Walsh: Thank you very much, that was very informative. Again we'll be taking questions and answers after everyone has completed, so please jot down your questions if you have any and we'll get to them in a few minutes. Next we'll be hearing from New York. I'd like to introduce Deborah Fryc, Program Specialist and Ken Gnirke, who is also a Program Specialist from the Office of Mental Health, Bureau of Children and Families, and Pam Tindall O'Brien an attorney from the counsel's office in the Office of Mental Health. Thank you New York team.

Deborah Fryc: Thank you. I am going to go through the questions very much the same way Vermont did. First I do have a correction to the draft summary. I see the age I misread it, it should be the age of our children is 5 to 18, not 15 to 18. Going through the questions:

Describe your SED waiver? New York State was approved to operate the waiver effective January 1, 1996. The populations served are again children 5 to 18 at entry. They can continue to 21 if they are enrolled prior to their 18<sup>th</sup> birthday, and they need to have a level of care in need of inpatient psychiatric. The average length of stay for the children in New York State in 2002 was 11 months. It seems to have gotten a little bit higher in 2003 we're now at 14 months. The average cost per child, we do look at New York State as slots, we have 610 slots that are budgeted at approximately \$46,000 per slot. In 2003 we had approximately 950 children in those 610 slots, and they averaged about \$30,000 when you look at it from an unduplicated count perspective.

Beneficiaries to date. Since 1996 we have had over 5,000 children in those slots. We started with a small number, 125 and gradually increased to the 610 slots we have today.

The waiver services. We offer six services in New York State. Individualized care coordination which is very equivalent to a case management, crisis response service, intensive in-home, a skill building service, respite and family support.

Most effective service. I'd say our individualized care service is probably our most effective service. We had a family satisfaction completed in 2001 and that was the service that the families acknowledged most utilization, but it also has to do with the way we finance our program as well.

QA monitoring. We monitor the quality of our program through annual site visits. We have 26 approved case management agencies that are audited annually. We also do a lot of desk reviews. This means that there are routine reviews of documentation performed in the office rather than in the field or at the clients home. We have a lot of reports that assist us in identifying where our problem areas are or where our really good areas are. We have monthly cost reports, we have characteristics reports, we monitor average lengths of stay, we manage incident reports, we also look at our quality indicators we look at the disposition at discharge, the length of stay and hospitalizations.

Family involvement in service planning. The family actually drives the service plan, so we're working towards some clinically good goals in our service planning and the family also works very closely in that development.

The history of development in New York State. Prior to 1996 New York State already had several 1915(c) waivers. We were also doing a lot in developing managed care plans, and we recognized this as being a very good community alternative to hospitalization placement.

Estimated costs. New York State has an imposed cap of \$46,000 per slot, and that's on average statewide. Many of our children have health insurance so the cost is less for those children, and some of them do exceed the \$46,000 cap.

Pam Tindall O'Brien: And the \$46,000 includes physician healthcare and meds, so that's one of the reasons that it's a lot higher than Vermont.

Deborah Fryc: Adequacy of the system of care. We hear reports that our providers have some difficulty in arranging for services for the families, and the families would like more services, but we think that the demand at this point is adequate to serve all the families.

Challenges of implementation. New York State is very large and rural, and it's sometimes often a challenge to try to get the services out to the children in the most rural areas of the state.

Ken Gnirke: Debbie, the only other thing I was going to add with the challenges to implementation, and I think it also comes under lessons learned, is the issue of we really want the waiver to be a catalyst towards the development of a system of care that uses both traditional and non-traditional services. What we're finding is the need for what we call a critical mass of slots in a particular locality to really have enough business per se to allow for those non-traditional services to flourish and for us to be able to sustain that network once it is developed.



Debbie Fryc: I think I'll move on to method to justify the costs. We've compared our population to the inpatient psychiatric under 21, with greater than 60 days hospitalized in the previous year.

Lessons learned. Similar to Vermont's program, I think it's always a challenge to try to make the program operation and the reimbursement fit so that it's flexible enough to meet the needs of the family and the unique needs of each child. I think if we had done this over we probably would have used a lot more evidence based practices and would have included a training strategy to do that. We'd also utilize a lot of family advocate agencies to help us in the development.

Medicaid Waiver Fit, programatically. In New York State we already had a pretty good system of care both in Medicaid and others financed by counties in New York State, a study conducted by Dr. John Lyons showed that the waiver included the correct target population, particularly important since we include both prior Medicaid eligibles and Medicaid eligibles of a family of one. We do use the deeming roles.

Financially. We find that the waiver is less costly than hospitalization, approximately half the cost of hospitalization. We find that there are some limits to what Medicaid will reimburse and that sometimes creates a problem for us.

Cross-agency collaboration. Funding. We do not integrate funding with other state level agencies at this point.

Pam Tindall O'Brien: Although we do serve foster children in the program. Foster children who are in foster family homes.

Debbie Fryc: So it's a homelike setting.

Program and policy cross-agency collaboration. There's not much overlap with the existing 1915(c) waivers. At the local level, or county, we have single points of access (SPOA) that are operated by local mental health units that include representatives from all children's programs, juvenile justice, probation, education, protection, child welfare and community groups.

Our monitoring, county mental health participates in our site visits along with the SPOAs who triage our children to the appropriate level of care. Our SPOAs not only do triaging for the waiver, they also do triaging for a variety of programs in New York State.

State funded programs. Besides the children deemed Medicaid eligible our counties also fund programs, and New York provides some reinvestment funds, and that reinvestment funding comes from state facility closures, similar to Vermont.

Pam Tindall O'Brien: The only thing I would add is that the other problem that we've had is that children who are in the waiver, their parents are not happy to be discharged from the waiver. They don't want to leave, and it's partly because even if they have private health insurance it doesn't cover the kinds of services that waiver does.

Ken Gnirke: I would say that issue of step down from the waiver is a big one, and I think if we had it to do over again we'd really design in an expectation that there's going to be an ebb and flow to the needs of the family and as those needs are reduced we would have the ability to still have the child in the waiver but at a much lower level than a fully funded waiver slot.

Debbie Fryc: I think that concludes New York State's presentation.

Marlene Walsh: Thank you very much, that was excellent. Okay, our next state is Kansas. We have with us Krista Cowger, Pam Alger, and Eric Van Allen from the mental health team. Thank you Kansas.

Krista Cowger: Thank you, we're just going to kind of follow the same format. I'll do some of the general overview, and then Eric Van Allen handles a lot of the number reporting for our waiver and so he'll address some of those issues, and Pam Alger is actually our team leader for children's mental health team here at SRS, so she's here to help us expand if there's anything that we miss, so we'll just jump right in.

Marlene Walsh: Okay, thank you.

Krista Cowger: Our SED waiver was approved in January of 1997. The population we serve are children identified as seriously emotionally disturbed who are at risk for imminent hospitalization.

Our age category is between the ages of 4 to 22, although we do have an exception process in place for children under the age of 4, and those approvals have to come directly from our office. Children have to have qualifying CBCL's and CAPUS scores. A CBCL of one, of any three subscales of a 70 and the CAPUS has to be a total of 100 or a score of 30 on any two. We also have an exception process for CBCL scores, again approval through our office, however we do not have an exception process for CAPUS.

The average length of time children are enrolled 267 days, or approximately nine months. Average cost per beneficiary \$14,626. On the issue with beneficiary served to date, we're currently updating our data system here in Kansas, so we don't have a cumulative total. We would estimate that to be approximately 5,000 children, however in FY '04 alone we served 2200 kids on our waiver.

We have four unique waiver services for the overview of SED services, and those are parent support, wraparound facilitation, respite care and independent living skills building. However it is important to understand that we have a full array of services that are available to children outside of the SED waiver and that the SED waiver in our state is not the only way you have access to mental health services. So the children on the waiver have access to these four unique services, but they also have access to a full array of mental health services such as case management, attendant care, in-home family therapy, etc. They also have access to dental, medical and vision services and we have extensive supports built in through the rehab option of our Medicaid State Plan.

As for the services themselves, the services actually that are identified as the most effective are not necessarily our waiver services. Attendant care and case management which are both general Medicaid services in the state of Kansas are actually recognized to be the most effective in maintaining children in their homes and communities. Specific to the waiver respite care is identified as our most effective service, and the service that is identified as the most appreciated or useful to families is parent support. All of this information is tracked through outcomes that are reported on every child in case management in the state of Kansas and as well we have a youth and family satisfaction survey that's carried out every year.

We monitor the waiver in a variety of ways. One of those is through the outcomes reporting that I had alluded to, as well as satisfaction surveying. We have external reviews done on a periodic basis, and we've done some special studies. We have a prior authorization that is required for each plan of care for a waiver child on the four waiver services, and that's done through our offices. Our monthly 372 reports as well as a tracking process for that prior authorization. We also are the licensing body for the 29 community mental health centers in the state of Kansas so our field staff conduct licensing visits on a bi-annual basis, and part of that would also be random chart reviews, and some of those certainly would be waiver charts. I think it's also important to understand that in Kansas we have consistent statewide training for each specialized service and wraparound facilitation, case management, attendant care, ICS workers, as well as we're about to roll out a respite care training.

How are families or caregivers involved in the plan. The philosophical basis in Kansas would be a family centered philosophy as well. Per regulations and contracts in the state of Kansas it is required that families be connected to and a full partner in the treatment planning process and wraparound is required for each and every plan of care or treatment plan for waiver children.

As far as the history, the services themselves were created to fit within the wraparound model, and the provision of community based services based on the family, child and provider, and other stake holder input throughout the state. We originally had two SAMHSA system of care grants within the state, and those were existing prior to the waiver. The data from those two sites was really useful in approaching the Legislature and showing them what the intensive community supports could do for families and how we could cost effectively keep kids in the community with intensive community support.

Challenges of implementation. I think retrospectively we would say that we initially over-managed the waiver. We initially had a slot system, we originally required prior authorization for every single service that was listed on a plan of care, so even though we only had the four waiver services we would also require prior authorization for case management attendant care. We found this to be kind of burdensome and not really very effective in implementing the waiver statewide. Currently now we only again require prior authorization for the four unique waiver services, and we use more of a bundled rate philosophy, we don't have a slot system. I'll let Eric talk a little bit about estimated costs.

Eric Van Allen: For the cost run, well actually this year, it's going to be finished up, and our estimated costs right now are \$14,626 like Krista said, per person, and that's for all Medicaid

services for any person served on the waiver so that would include their mental health services, their physical health services, etc. That's compared to approximately \$27,000 per person for Medicaid costs for those in the hospital. For our entire year of FY 03, we were around \$26m and that included SGF and our FFP for that year.

Krista Cowger: In regards to the adequacy of the system of care, again it's important to understand that we had children's services in existence, there was a system of care established within our state prior to the waiver. Realistically, however, the funding for the waiver Eric alluded to this, in some respects is primarily SRS dollars, Medicaid dollars and FFP. We do collaborate with our financial determination office to the local office and the CMHCs to establish the financial eligibility piece. This is the same process that a family would go through for a general Medicaid application. I think part of the reinforcement through the system of care is that again, the requirement the wraparound has to occur for every single waiver plan of care, and we really encourage natural supports and other agency involvement within that. Cost neutrality, Eric do you want to address that?

Eric Van Allen: Sure. Cost neutrality is based on total inpatient costs for any child under the age of 22. How that was determined is any child that spent one day in the hospital, their total institutional costs were averaged and that was divided by the total number of children in the institution. That did come out to \$26,892 per person. That is compared to our total number of costs for Medicaid services, all services for those kids on the waiver, and that was \$14,626. Our actual from last year was \$13,587, so we were actually below our cost neutrality by about \$1,000 per child.

Krista Cowger: In regards to lessons learned, I think again we'd go back to our challenges with implementation. Really the piece that we would have not initiated the flaws if we would have thought a little more about some of those things, and so that over-management of the waiver initially would be something that we would do different should we have to start over. And as far as how the Medicaid waiver system within the system of care, we've addressed that in a couple of different ways, but again I think it's important to understand that there's a larger system of care than the children just receiving the SED waiver services, and that realistically only about 13% of all children identified as SED in Kansas are actually served on the waiver, which is equivalent to about one-third of the kids getting in-home support.

Cross agency collaboration integrated funding. Again the funding structure is directly from our agency, however service collaboration at the local level occurs through the wraparound process, each agency would be responsible for the services they deliver as far as the local service delivery and the local wraparound meaning.

Funding. We really have a philosophy that funding process should be seamless to the user family, that the user family shouldn't have to be concerned about who's coming with what dollars to the table, that that shouldn't be something they have to worry about, all they should need to worry about is whether or not their child's needs are being met. And as far as if we have state funded programs in our state that serve SED children who are not Medicaid beneficiaries, again, yes we do, and in actuality by state regulation community mental health centers are required to serve individuals within their community regardless of their ability to pay, and

CMHCs receive funding annually from our agency to be able to serve those people in their communities. Pam, are there things that you feel we didn't capture?

Pam Alger: I think we're okay.

Krista Cowger: All right, that's everything that we had.

Marlene Walsh: Thank you Kansas we really appreciate it. Okay, Wisconsin next, Kristina Stuart and Julie Bryda from the Bureau of Developmental Disabilities Services, in the Department of Health and Family Services.

Kristina Stuart: Thank you this is Kristina Stuart. I'm a children's waiver specialist, and we have just within the last couple of weeks been renamed to the Bureau of Long Term Support, another organizational delight. My colleague Julie Bryda is also on the phone. Unfortunately our manager Beth Wroblewski, who's listed on the grid that Nirvana developed was called away to another meeting today, but certainly was sorry to miss this event. So we'll go ahead and describe the questions first, and then make sure we've hit all the bullet points underneath, and we'll just go back and forth with information as we go through the questions.

So first, describing our SED waiver. The SED waiver in Wisconsin is part of a set of three sister waivers that were developed simultaneously and approved simultaneously by CMS. They were originally designed to be one large waiver but then we were given guidance that we should separate them out by target population. So the other two waivers are for children with physical disabilities and children with development disabilities. They are almost exactly the same in terms of the services delivered and I'll mention that a little bit more when we get to the service section. We are very new at this new SED waiver. We were approved late in 2003 and began implementation January 1 of this year, so we're in month eight, and it's been an exciting ride so far, and that's due in part to the fact that one of the services approved under the waiver was previously delivered under Medicaid fee for service, and that would be intensive at home autism treatment services, and so many of the families who had been receiving that service under Medicaid fee for service in Wisconsin were transitioned to this waiver as of the start of the new year, so it's been exciting to have families move into getting that service in a new way.

Okay, so the history of its development. These waivers were part of a broader system redesign that began in Wisconsin around 1997 and the name of our initiative was Children's Long Term Support Redesign, and it was mainly a movement started by families saying look, in Wisconsin we have so many different programs to serve children with long term support needs, but they are very confusing to figure out and how do we mesh them all together. So it was really a parent led initiative, with a children's committee made up primarily of families that then partnered with our departments to begin making some of these changes and suggesting how that could happen, and it took a long time as you realize to come to fruition with these waivers which are just one part of our overall system redesign.

Some other I think interesting and unique features are we've developed a children's functional screen, which is a web-based module which reviews functional eligibility for not only the children's waivers, but also a state funded program called the Family Support Program, and the

Katie Beckett program which is our waiver for children to receive Medicaid eligibility, so we've developed this and it's almost implemented now, so that's another piece of our broader system redesign that we're working on implementing in Wisconsin.

Challenges with implementation. I alluded to this a little bit before in terms of having people who have received services in one way then become our first group of new recipients under the SED waiver, and that has proved to be a real challenge. Julie do you want to say anything about that transition?

Julie Bryda: Sure, in January we transitioned almost 1,400 children from Medicaid fee for service to the children's waivers, all at once. So we had to work with, actually we started with 52 counties within our system to get all these children eligible, review their functional eligibility, because as you know, for the Medicaid service the level of care process isn't a part of that, so we had to go back and now re-determine eligibility and we had to introduce a new layer of oversight, which would be our county system, and service coordination was another new piece that these families weren't used to. So it's been quite an interesting transition to say the least. So that's probably been our biggest challenge in that we had so many children to get on the waiver all at once and counties that had to get used to and learn a brand new children's waiver. Although they had experience with adult waivers, as we know serving the children and dealing with a family centered process is much different than serving an individual adult.

In the meantime, as we were transitioning these children on the intensive at home autism, counties were submitting applications for children not part of this group, particularly in the SED population, and it was interesting in that this was a whole brand new area for counties, obviously. Staff in the mental health area is not familiar with waivers and implementing a waiver and all that goes with that, so we spend a fair amount of time, we have in these eight months, in training staff as to how to implement and access a waiver in general. Which has been very exciting, and mental health staff who aren't used to the flexibility that a waiver offers have really embraced this whole process, although it has been somewhat painful in that it is pretty technical and complex, if you're not used to that. The other thing that's exciting with our children's waiver, our children's waiver does fund actually 18 different services so as you can imagine, as most waivers that you're all familiar with accessing, staff in the mental health area serving children with severe emotional disturbance were not used to having such an array of services to choose from, and actually to work with in general, which has really I think one of our later questions talks about the adequacy of the system. We did find that of course the mental health system for children in particular didn't have the array of service providers readily available as we do in the adult system. So in the last eight months we have seen a tremendous interest among the provider system in stepping up to the plate finally, being that there is waiver funding now available in developing and working with counties to develop services to support families with children and of severe emotional disturbance in their homes. So that's been a very exciting result of all this.

Kristina Stuart: Not to dwell on the challenges, but just something of note that I think might be unique to Wisconsin is currently we only have state funded slots available for intensive autism treatment services. That's just one of our services out of all of those many services listed in the grid. We only have funds for the intensive at home autism slots, and then once children

transition out of that service, which only lasts for three years, the children continue in what's called an ongoing slot, where they then can select from the broader array of services. So we have this tempting array of services that could be available however there are no state funds available to match to those services except for this group of children with autism. A county in Wisconsin, however, could use local funds to draw down slots to use some of those broad array of services, so we have kind of a bifurcated implementation system going on where people are saying, isn't this the autism waiver, and we say no, it's a broader waiver for children with SED, but the only state funded slots right now are for children with autism. So that's another challenge as we're rolling into the system here.

Then the last challenge I want to note has to do with our level of care and functional termination process. We do have a level of care similar to how we approve level of care for the Katie Beckett waiver. However we also are getting the Disability Determination Bureau disability determination for kids with SED in order to be eligible for the waiver, and because of the nature of children with SED on their diagnosis and functional needs, its taking six to eight months sometimes to get the DDD clearance. So we've actually sent a question to CMS to our regional rep and asked them if it's necessary that we get DDD determination or if our level of care determination could be sufficient in granting waiver eligibility functionally, which would really let us process kids with SED more quickly.

Okay, moving on to estimated costs. We have \$26.5m available for our state biennium, which is July 1, 2003 to June 2005 to provide state funded slots, but again those are only for children with autism. So any other funding would have to be provided by a county to draw down other federal slots. Our assumption for rates are that it would be \$96.00 a day for the intensive services and \$28.60 a day for children who have left the intensive phase of the waiver. But again, those are just averages, and it's more based on the child's individual service plan and we just have to stay within those averages for our big pot.

Adequacy of system of care, I think we've addressed that in some detail. We do have other programs in the state that support children with SED, even those who are not Medicaid eligible. We have what's called a family support program that's all state funds that's been going on in Wisconsin since 1981, and that serves almost exactly the same population of children who are eligible for the waiver and is very flexible state funding up to \$3,000 per family per year to provide whatever it is the family determines they need, it could be a ramp, it could be any number of flexible supports for families. We've also had a mental health redesign in Wisconsin that we're partnering with, and they're implementing different mental health pilot activities currently. Unfortunately there's not a lot of focus on children at this time with the mental health redesign, so we're working to try to address that in partnership with them. Anything else you want to say about adequacy Julie?

Julie Bryda: No, I think we covered it all.

Kristina Stuart: Okay, cost neutrality. What we did for community costs is we looked at children who had severe emotional disturbance who were on COP, and COP is another state funded flexible program in Wisconsin primarily for adults, but some children had always used a little bit of COP funding. We used that as the basis for community costs, and then for

institutional costs we used a federal report, the 2082 Report, and tried to get Medicaid card costs for children on Katie Beckett.

Let's see, lessons learned. I think we've already talked about that a little bit. I think implementing a new system with a bunch of families who had been getting it under another system has been a real challenge and finally we're starting to feel like, okay, we've got this under control. But we've had a lot of appeals and a lot of families who are just uncertain about what it means to be in this new system, so that's been a real challenge.

Question eight fitting into the system of care, I think we've covered that.

Cross agency collaboration, integrated funding and monitoring QA/QI. Julie do you want to talk about the monitoring piece with the CIS?

Julie Bryda: Sure. Wisconsin already had a quality system in place that we at this time are accessing where we have field staff, I think much like Kansas indicated who go out there and do home visits, site visits with both families and the counties, do record reviews, we also ask in the initial application of the children's waiver that the service coordinator does identify outcomes for each particular service that the waiver funds, so at this time we have accessed the existing quality assurance model that we had with our previous 1915(c) waivers, we are right now though researching how to modify this to make it more specific for families. So there's more to come on that. We recognize that we would need to modify that and I think in this eight months we've had some reinforcement of that. But again, we do in this waiver much like our other waivers in Wisconsin, family involvement, consumer involvement, guardian involvement, is a critical piece and required throughout this entire process. So this was a process we were very used to in Wisconsin and that is business as usual in our counties.

Kristina Stuart: Julie could you talk a little bit about how families are involved in the development of an ISP, individual support plan.

Julie Bryda: Yes, the ISP, individual support plan is developed with the family and must be authorized by the family. The family does sign a document which basically is the document saying the family is in agreement with these services and the outcome. So if a family does not sign it then we will not approve the plan. We require the county to negotiate and work with the family to be sure that the family's needs from their perspective is being met as well. We also do annual parent surveys, guardian satisfaction surveys, that we will be doing. Again, we just started in January so that will be coming as well.

Kristina Stuart: Okay, in terms of integrated funding in question nine, at this point really the only integrated funding in terms of waiver funding would be that it would be state or local funds that could be matched to the waiver slots. We have not integrated financially with any other program. Programatically we are working closely with our partners to make sure that within our broader system of redesign that we're not duplicating services. With the children's functional screen, we're trying to make sure that we're reviewing children functionally for as many programs as we can simultaneously, and just working to make sure that when service coordinators are trained they're aware of the system of services available for all children. One of



our state coordinators who works across programs recently convened a work group to have us work with the folks from foster care, public health, and the mental health system to try to sit down and make sure we've appropriately mapped out the system of all of the supports for children in this group, and we've got a draft grid developed that we're going to be sharing with county service coordinator. We just rely so heavily on our county partners, as that's the way all services are implemented in Wisconsin through the counties, to try to make sure they're well trained and how to operationalize the new waiver.

And I was just looking at the bullet points after the questions. Many of these we don't have data on yet because we haven't had a full calendar year yet. So length of time enrolled, cost per beneficiary and services to date, we think there are about 100 children receiving SED waiver spots right now. We at the state determine when an application comes in if its DD or SED, and so there are approximately 100 as of right now in our broader 1400 children who are currently on the waiver. At this point we do have quality assurance tools but we don't know which ones are most effective yet. So those things will be coming, and I think we've mentioned that families and caregivers were the impetus for the full redesign and are closely involved in the ongoing children's committee in reviewing all the actions that the state takes. So, I'm afraid we've taken too much time, and I'll end there.

Marlene Walsh: Thank you very much. Indiana has Beth Fetters, Katie Howard and Betty Walton joining us today. They're Medicaid waiver managers from, I'm sorry Katie and Betty, I'm not sure if you're from the same part of the organization, but thank you for your time today.

Beth Fetters: Thank you this is Beth Fetters, and I'm going to go ahead and describe the waiver and I'm going to ask Betty Walton to answer the questions regarding the history and the systems of care, agency collaboration and those things.

Our waiver was approved on February 1, 2004, so it's very new, we're only into it about seven months now and we asked for a waiver statewide within Indiana, so we have waiver service available in 10 Indiana counties. It's for children with serious emotional disturbance age 4 to 22 who are at risk of state psychiatric hospitalization. We selected the 10 sites based on our systems of care and how well developed the system of care was in those areas. We may extend services to other areas in years two and three, but that decision has not been made yet.

The services that we provide are the same services that Kansas provides. We have respite care, independent living skills, family support and training and wraparound facilitation. We have some limits on respite care, it may be provided only if the child and family is participating in other intensive treatment and waiver services, and there is a limit on respite care of \$840 per year. Our costs, we don't know what our costs are yet since our waiver is so new, but we projected our waiver costs and our regular Medicaid costs to be around \$22,000 per year, and that compares to around \$57,000 for hospitalization. But the D-factor was derived from expenditures from a federally funded system of care here in Indianapolis, a utilization study analyzed the service and cost records of the children discharged from that system of care and then the percentages of service utilization were used to project the rate of utilization of waiver services as well as the regular Medicaid expenses. So far we've had 15 applications taken, we

have 15 waiver applications. About half of those applications are children who would not have been eligible for Medicaid had it not been for the waiver.

We have some of the same challenges that other states have, particularly the same one as Wisconsin so if Wisconsin ever gets an answer from CMS on the disability issue I would be interested in hearing that. That particular issue of children having to go through a medical review team here in Indiana to be determined disabled is what holds up most of our applications. We can get level of care determined pretty quickly, but we have to wait on disability determinations for weeks and usually several months, so that's held up a lot of action on our waiver.

Other challenges we've had, the challenges with our level of care assessment tool, mental health centers have complained a bit that it's so time consuming and they've had some difficulty determining the process for getting that completed and getting that in to us. Another challenge is the provider community development and helping providers understand what it means to be certified as a Medicaid provider, and going through that process for enrollment into Medicaid. I'm going to turn it over to Betty and let her discuss some other issues.

Betty Walton: Hi I've been dealing with the waiver since it developed in Indiana. There was a committee that was formed to deal with a new law here to address the relinquishment of custody issue. We had problems with children as in most states where parents were giving up custody to access treatment. So one of the solutions this cross-systems committee came up with was to pursue the waiver, and I was asked to help put together a task force which was truly cross-system, including Department of Corrections and patients on welfare. Since then, our application was filed. We do have funding from across systems for our mesh, we're very pleased with it, we have some money from Department of Corrections, some from Department of Education and Medicaid and DMHA. In Indiana there is other state agency money for children, but it's limited or capped if a family's income is over 200% of poverty they're not eligible. So for both that and Medicaid if a family has a lot of means it has difficulty accessing intensive levels of service.

So that's how the waiver came about. At the same time we've been developing systems of care in Indiana very assertively these have gone hand in hand. We had two federally funded sites, as Beth mentioned, and had child welfare and mental health work together to form more sites, Legislation was passed setting a standard for that, and from that we learned that we really needed on-site coaching and consistent policy and developed a technical assistance center. The sites that have matured the most have actually been the sites for the pilot waiver, and as far as the adequacy of our systems of care we have over 31 community mental health centers in our state, all provide some children's services, about half of the state has what is thought of as truly a system of care developing that is more of a cross-system approach. Care sites implementing the waiver.

As far as how we're monitoring this, we're using a functional assessment that is Indiana home grown, called the Happy C, similar to the CAPUS and the CBCL, we're also working with the University and hope to have a family satisfaction survey follow the families over the first three years of our waiver to see what their experience is. So the two fit together, but as Vermont said, this is a funding mechanism, it's serving a very small percentage of our children who are

receiving mental health services and receiving services through systems of care. I think some of our systems of care have targeted really very different populations and so both the mechanism of implementing the waiver and the technology has been a challenge, and developing intensive community based alternatives for children with severe problems in some parts of our state is a challenge. Is there anything Katie and Beth that I've forgotten.

Beth Fetters: I think you've covered everything Betty.

Betty Walton: So we'll stop and wait for questions.

Marlene Walsh: Thank you very much everyone. We'll open the session now to questions.

Doug could you please explain how to ask a question?

### **Question and Answer Session**

Operator: Our first question is coming from the line of Amy Starin. Ms. Starin please state your question.

Amy Starin: Hi, this is Amy Starin from Illinois. Thank you for the wonderful presentation. It is really very helpful information. I'm curious to hear from any of the states what the experience is like for the families in applying for the waivers, whether it's something that they do on their own or if they have assistance from some part of the system to get them into the waiver slots.

Kansas: This is Kansas. I can talk to you a little bit about how that works in our state. I have kind of duplicate knowledge of that, I was a family member of a child that received waiver services and I also worked as a case manager for several years in a community mental health center. But essentially the mental health center takes the lead in assisting the family in applying for the waiver. They would bring the packet of paperwork to the family, this would contain the CBCL, the basic eligibility information, the financial pieces too, and the case manager would be of whatever help they could be to the family in getting that completed. The QMHP at the mental health center would make the determination based on the CAPUS and whether or not they qualify SED, and then the case manager would also assist the family further by seeing that, that financial paperwork that needs to go into our local SRS office for the financial eligibility, they would also assist the family in getting that turned in. So, in Kansas the mental health center really is the lead agency, and they give the family just as much assistance as they possibly can.

New York: In New York we use our single points of access which are really our county representatives. The family can either self refer or have their clinician complete a referral form, and then the child is evaluated for waiver and other services.

New York: And in New York with our county-based single points of access what we're asking these single points of access to do is to meet with the family, and they have parent representatives there to help the families through the process, and it really is a process where we look at the needs of that particular family and we try and match up the services that could most adequately meet those needs. That might involve a waiver, but it could involve a whole host of other services that would be made available to that family.

Wisconsin: In Wisconsin the family would work with a county service coordinator to determine the same kind of process, what programs and services might be available to that family in addition to being eligible for the waiver.

Marlene Walsh: Thank you. Speakers, again, I just wanted to remind you that feel free to ask your colleagues or other speakers about their waivers. When we had talked earlier preparing for this there was a suggestion that there be an opportunity and please feel free to do that with each other. Doug are there any other questions in the queue.

Operator: Our next question is coming from the line of Joel Zemmer. Mr. Zemmer please state your question.

Joel Zemmer: Hi, I guess I heard quite a bit of discussion about cost effectiveness. I wonder this is kind of a multiple part question, but how much institutionalization were you able to reduce from your inpatient length of stay through the provision of waiver services, and does this appear to be any kind of an area of concern for people, because this is something that in the past, at least I think you can't really deinstitutionalize SED kids, and so I'm just curious what experience you have with continual, or residual institutionalization or institutional cost for kids in the waiver and how that plays into the cost effectiveness formula. Thank you.

Marlene Walsh: Does everyone understand Joel's question?

Joel Zemmer: Should I restate it, would that be helpful? It's basically your D-prime value, how do you make that work say if you can only deinstitutionalize an individual by 50% of their inpatient cost. Or, I guess there's some average that you figured that you could cut back on hospital costs through the provision of waiver services.

New York: I would say New York's answer to that is that we have not taken beds offline. However, we had done a survey as to how many beds were needed, and we did not build 450 beds that were supposed to have been built. So we stopped building beds, we haven't actually been able to take down beds yet.

New York: We do find that despite the fact that a large number, all of the kids are at risk of institutional placement a very large percentage of the children that are served in the waiver are able to avoid institutional placement. So in that sense we're successful for the children that we serve, but as Pam was saying we have not taken beds offline based on the success of the waiver in New York State.

Indiana: It's really early for us, but we're aware that many of our children with severe problems other systems to residential treatment and that kind of thing. We have reduced our state hospital beds prior to the waiver by 20 beds, but often we have waiting lists and there's an ongoing need for intensive services at all levels.

Vermont: We did take beds offline. We took all of our institutional beds offline, which was the youth treatment program in hospitals. We do fund, of course, inpatient care and psychiatric units

in general hospitals, and we also are aware that inpatient hospitalization doesn't necessarily lead only to the place where it happens and community utilizations.. That's one of the things that we look and we try not to...

Joel Zemmer: I'm sorry you were breaking up so I didn't really hear what you said. I heard you start to say that you still have kids getting hospital care in private psychiatric beds.

Vermont: They're not really private psychiatric beds they're actually inpatient units that in Vermont are located in general hospitals.

Joel Zemmer: But doesn't that count towards your cost effectiveness?

Vermont: Yes.

Joel Zemmer: I was just curious what percentage can you reduce of the inpatient utilization by the provision of waiver services?

Vermont: I don't know what our stats going back to 1982 when we started, it's hard to compare because it's such a different time just in the system's mental health services for kids, but I know in the last five years, maybe in the last four years, we've cut our inpatient, the average length of stay that a child goes inpatient from 33 days down to 9, over the last four years.

Joel Zemmer: Okay. That's a pretty significant reduction.

Kansas: This is Kansas here and I guess I was a little confused on the question, but we can address a few of those. Kansas since the implementation of our waiver we have actually lost one state hospital, and I'm sure exactly how many beds that was, but out of the three we're now down to two state hospitals, we've decreased total number of bed days from 45,000 bed days in 1997 to approximately 11,000 bed days in FY 02, and that number has continued to decrease. I think there was some questions about how that worked into the financial the D-prime and the G-prime, and basically how that works is individuals who are institutionalized at any particular time are part of your G-prime, and that's your total dollars you've spent while institutionalized, and your D-prime is those individuals on the waiver and they may or may not have to have some institutional time and that dollar still counts in their time.

Joel Zemmer: Right, and I guess the reason why I asked this question, and I know it's kind of a morbid question, but when we looked a few years ago at doing a home and community based waiver for kids that used 30 or more days of inpatient care per year, we didn't think we could reduce their use of hospital more than 50%. Now maybe that was not a very realistic assumption on our part.

Kansas: I think Kansas has seen a dramatic decrease in the number of, I think the best way to say it is with a broad array of community based services, a lot of supports in the community, we've seen a dramatic decrease not only in the length of days that they're staying there. So we're going from averaging, I don't know, I'm throwing out rough numbers here, but a year or a

long duration of time say in a state institution down to like our average length of stay now is 14 days, so we've seen a dramatic decrease.

Joel Zemmer: And that decrease is attributable to the provision of waiver services?

Kansas: In part.

Kansas: In part, it's also partly, at the same time that we have the waiver we're also building other community resources as well, we have those things going on at the same time.

Joel Zemmer: Those are Medicaid funded though too?

Kansas: We built some intensive in-home services through the Rehab option into the general Medicaid plan, we enhanced the array of service through the waiver and then in addition to that, separate from Medicaid eligibility we have state general fund only dollars to fund services for kids who do not qualify for Medicaid or the waiver.

Joel Zemmer. Okay, thank you.

Marlene Walsh: Are there any other questions in the queue?

Operator: There are no further questions in the queue at the moment.

Marlene Walsh: Okay, I have one, could you please share whether or not you developed a unique assessment tool to determine level of care eligibility for this waiver. I saw some very interesting information from Kansas, but I was wondering if the other states also developed unique assessment tools for this particular waiver, and if you have them, is it something that you can share electronically with us so that we can disseminate it to our grantees?

Indiana: In Indiana we were really mentored by Kansas. We really appreciate that through our process, and began with their general level of care instruments, had a cross-system group that worked for a year to enhance it, and I use that with a little bit of tongue in cheek, because it's longer, but we'd be happy to share that.

Marlene Walsh: Great, if you could just forward it to Nirvana, we'll forward it to our grantees. Kansas, do you have yours that you can share. I mean I have a hard copy, but do you have an electronic?

Kansas: We have our clinical eligibility packet. I only have that in hard copy, I'm not aware of us having that in electronic form.

Marlene Walsh: Okay, thank you.

Kansas: I guess I could address that too. It's really a collection of assessment tools and the processes and the SED definition that we use to determine whether or not a child qualifies for the waiver.

Marlene Walsh: Thank you.

Wisconsin: This is Wisconsin and as we referenced we are almost completed developing our online web-based functional eligibility which will ultimately determine level of care, including the waivers. We do have a hard copy of what is the current level of care information. I think we might have it available electronically as well, so I could send that to you, it's exactly the same as our Katie Beckett program.

Marlene Walsh: Thank you. So you're close to having a web enabled online application process for all of your Medicaid waivers did you say in Wisconsin?

Wisconsin: Well, we're working on the children's functional screen. Wisconsin has already gone through an adult redesign called Family Care, and they do already have for the adult population an online web functional eligibility for use by screeners, and we are currently doing inter-rater reliability testing with our children component of that, so we're going to be up hopefully by 2005 online, and we've tested it, it's going through it's final phases right now. We're really excited about that.

Marlene Walsh: Wow, that's quite impressive.

Wisconsin: It's been a huge project.

Marlene Walsh: Yeah, I can imagine. Any other questions in the queue Doug?

New York: This is New York State. New York State developed their own level of care instrument based on target criteria, and use of a Universal referral form, but we're moving towards utilizing the child assessment needs survey, the CANS for our level of care instrument.

New York: Also our SED definition which is one of the criteria for eligibility to the waiver is fairly specific in terms of diagnosis, functional level of functioning, as well as CGAS score.

Marlene Walsh: Thank you, who was that that just spoke, the last caller.

New York: That was New York Ken Gnrke.

Marlene Walsh: Thank you Ken. Okay, Doug are there any other questions in the queue?

Operator: Our next question comes from the line of Toni Rozanski. Ms. Rozanski please state your question?

Toni Rozanski: Hi, my question has to do with the general definition of SED as you are using it in the waiver and is there just a generally recognized definition that all states are using in waivers or are you defining it by your state when you're writing your waiver. Is there a difference?

Kansas: Kansas does have a statewide standard definition for SED, and it follows pretty much the federal definition. Other than it's a little bit broader because we go through the ages - well kids under 22, whereas the federal definition is 18.

Indiana: Our definition for children with SED also follows the federal guideline. It doesn't include autism though, that falls under our developmental disability services. We do have a financial cap, they can't be over the 200% of poverty level.

New York: For New York we go beyond the federal definition of SED, we have our own specific definition, which is as I said before fairly specific in terms of diagnosis, functional assessment as well as the CGAS score.

Marlene Walsh: Anybody else? Any other questions in the queue Doug?

Operator: There are no further questions at this time?

Marlene Walsh: Speakers do you have any questions for each other.

New York: New York has a question. The question that we have is do the other states serve the foster care population, and if so only in foster homes or also in group homes?

Kansas: Kansas serves any child based on clinical eligibility, including foster care children. We do prefer that kids are in a family home setting. If a kid is on the waiver and has a short-term leg hospital stay, under two weeks, the waiver would remain intact. If it exceeded that it would not.

Indiana: This is Indiana our waiver is also for community based care. If the child went into a group home that would probably be considered residential care and disqualify them unless it was a crisis respite situation.

Vermont: Vermont ideally would like to keep the kids in their own home and look after them there. If not there, our waiver does fund for therapeutic foster care, and then we do have a couple of homes in parts of the state that are group therapeutic foster homes. Their staff model, and again they're ideally in the child's own community.

Wisconsin: Our definition for SED is based upon the admission criteria for Medicaid funded psychiatric institutions, and we do have a set of criteria we've developed and the child does have to show symptomology across all settings of life. We have just a three page document and I'd be glad to share with Nirvana if anyone would like to look at it in detail.

Marlene Walsh: Great thank you.

Wisconsin: We'll forward that to everyone.

Marlene Walsh: Any other questions at this point?



Operator: We have another question coming in on queue. Our next question will be coming from the line of Heather Preslar. Ms. Preslar, please state your question.

Heather Preslar: Yes, good afternoon. This is Heather, I'm in Massachusetts working with the state on the CTAC grant and I'm just wondering if you guys have any recommendations as you have gone through the application process for the waiver, of anything to think about of partners to collaborate with and making sure the waiver meets you know different stake holders needs and those issues. Because we're all on the planning side of this and in a way people are talking about what's going on now, but the planning part is kind of important to us, and any kind of words of advice about the application planning process itself.

Indiana: This is Indiana again, we're very close to the planning process, it hasn't been that long ago, and it was essential to have partners from all the child service systems, in fact this has been the impetus for some ongoing cross system work that hadn't occurred here before we were truly in silos. Currently we're working with child welfare to develop screening of all the children placed in substitute care for mental health issues, and that partnership just wouldn't have happened without this, so I think it's essential all that you can do to involve families and advocates in the other systems is essential. We find it remarkable that we have community correction dollars in our waiver and they would like to find a way to shift some funding they say so that youths don't end up in their service. Now how to make this all work is truly the challenge, but we found that spirit very important.

New York: For New York I would say one of the most crucial components is really working with family groups to understand the types of services that could have made a difference early on and avoided that path towards institutional care and also the specific services that children that have been in inpatient care and institutional care, what are the types of support that really do make a difference for families, and we've heard a lot about respite care, I think it has to be unique to the particular locality that you're looking at and what are the missing components in the local system of care.

Vermont: This is Vermont, and I would also, we've talked a lot about determining eligibility and what types of services the waivers will have, but I would also encourage you to look at, how do we know when the child has progressed enough for them to transition off? Develop some type of mechanism to gauge that, that's something we've struggled with.

Heather Preslar: And now do you have kind of a protocol that you go by to determine that, like stats you look at, or?

Vermont: We look at, it's really anecdotal, we look at was the child recently hospitalized, or in hospital diversion programs, calls to crisis teams, we do have the CBCL that we try and look at really closely to just gauge progress to know when a child is at least making progress, but that doesn't specifically answer how do we know when they're able to transition off. We find that local teams will often say, but if you take the child off the waiver they will be in the hospital even though they're doing really well at the time and that's something that again, we try and work that out on a case by case basis.

Kansas: As far as building services for the waiver, when we were in the planning stages of our waiver we had cross system stake holder groups that included families that helped define what services needed to be a part of the waiver. On an ongoing basis we utilize our satisfaction data, and then we have periodic focus groups with families, and now that we're up for renewal we will be doing some of the same work again, and we will in '05 be adding to the array of services in the waiver based on some of the work that we've done all along.

Wisconsin: This is Wisconsin having also gone through the screening process. It was the children's committee that was really family led, that provided the true vision for how they wanted the system redesigned to look, and that easily let us build the vision for what we wanted the waiver to do. On the other side, the implementation side it's just so vital to get all these silo folks together. As my colleague Julie referenced earlier that we have this new home and community based waiver for SED. Well that's traditionally been done through the DD world in Wisconsin, and we're now partnering with the folks from mental health to train them on what that looks like and how can we all work together. So thinking about how services are delivered in your state, and what types of silos, since we all have to have them and who needs to do what for implementation to really make it effective in the real world.

Heather Preslar: Well thank you, this is helpful, definitely.

Marlene Walsh: Okay, well it's coming up to 90 minutes, are there any other questions from either speakers or from other participants?

Operator: We have a question in queue. The question is coming from the line of Kristi Plotner. Ms. Plotner please state your question.

Kristi Plotner: I have one question about some of the rates that were discussed and how that's paid. Vermont for example gave an example of \$150.00 a day, and I'm wondering if that's an average rate or if you're paying that on a case rate, or if each of the individual services that are covered have a specific reimbursement rate themselves.

Vermont: We pay out services based on a per diem, but the individual cost of each of the covered services goes into the creation of the rate for that per diem.

Kristi Plotner: Okay, so for example if you had one child that got three services their per diem rate would be different than a child that got four services?

Vermont: That's right.

Kristi Plotner: Okay.

Kansas: Our services are billed on a fee for service basis, so a little different. Contingent upon staying within the cost neutrality requirements though.

New York: This is New York our services are fee for service, with the exception of our case management, our individualized care which is a case rate.

Wisconsin: In Wisconsin the state's currently only paying for slots for children with autism, and that's an average, there's a daily rate that's paid out. For children receiving ongoing services which are that of a broader array of services, we pay based on actual, we pay the average daily rate to the counties who then negotiate individual rates with the vendors.

Kristi Plotner: Thank you.

Indiana: We have a question to ask the other waiver states. Some of you are managing without slots, and using other approaches, and could you talk a little bit more about how you do that. I know someone said they had a certain amount of slots that they had more children than they had slots. So, we're using the traditional slot method but would like to maximize what we're doing, and would like to learn from your experience.

Vermont: I think that our spending is really the availability of the state match. We have room within the cost neutrality formula to serve more kids, but if we can't come up with the match then that becomes our ceiling.

Wisconsin: I would say that's also true in Wisconsin, for state funded slots we have to stay within our average allotment for the state's biennial budget, but our counties are free to use any other unmatched dollars to draw down additional federal slots which we do have available under our cost neutrality agreement, and we actively work with them to identify those match opportunities.

Marlene Walsh: Does that answer your question?

Indiana: To some degree. I think it's a learning experience to figure out how to maximize resources and manage this.

Marlene Walsh: If that's of particular interest we can certainly have a separate call with you and your team and states that they do not have slots, that you know we can spend some more substantive time talking about the nuts and bolts, like how does it really work, how is it really implemented if that would help. If you could just let us know.

Indiana: Okay, thank you.

Marlene Walsh: Any other questions.

Kansas: I didn't say anything about managing. We've managed our waiver fiscally in a variety of ways over the years, and we're pretty happy with what we have today, and I just think sort of a targeted call around that is probably easier. We do not have slots, I'll say that.

Marlene Walsh: Okay, great. Thank you Kansas. Any other questions?

Operator: We have another question in queue, would you like to take it.

Marlene Walsh: Okay thank you.

Operator: The next question will be coming from the line of Joel Zemmer. Mr. Zemmer please state your question.

Marlene Walsh: Joel, what state are you from?

Joel Zemmer: I'm from the Missouri Department of Mental Health.

Marlene Walsh: Thank you.

Joel Zemmer: We have several HCBS waivers, particularly the one I'm familiar with is our waiver for persons with developmental disabilities and we also have 1915(b) waivers, managed care, for physical healthcare primarily, but we've been told by CMS in the past that if somebody is in our managed care waiver that they can't also be in an HCBS waiver and I just wondered if any of the states has had any experience with CMS on that?

Indiana: We have that issue in this state and it's just another one of those things sometimes that delays enrollment into a waiver because we have to disenroll them from managed care before they can be enrolled in the waiver. We're of the same impression, that if you're in the 1915(b) waiver you can't be in home and community based waiver.

Marlene Walsh: That answer your question Joel?

Joel Zemmer: Yes.

Marlene Walsh: Any other questions before we close. Certainly if folks, we could take one more question if we have one, but we can also ask folks if they think of other questions or have questions they can send us the questions and we can forward it to our colleagues out in the states. Any other questions in the queue Doug?

Operator: There are no further questions in queue?

Marlene Walsh: Any questions from the speakers. Thank you. I would like to thank everyone for their interest in this audio conference today, especially for the speakers. Thank you very much for your time and effort. I just want to remind the participants that we will be sending you all an evaluation in a couple of days, and please take a couple of minutes to complete it so that we can know how this served your purposes in terms of answering questions to help you move along your goals for your proposal as well as how we can provide additional technical assistance to our grantees. Nirvana, again, thank you very much. And to all presenters, could you just stay on the line a little bit. Also, CTAC grantees we will be announcing an all grantee call soon, so please try to participate in that, and we hope that this has been helpful to you today. Thank you everyone.

**Subsequent to the audio conference, we received clarification from CMS on three questions that were raised.**

There appeared to have been three questions raised - 2 in the transcript, 1 in the evaluations.

The first was whether the Medicaid determination of disability (a criterion for basic Medicaid eligibility) could be combined with the level of care determination for the waiver. There was concern that Medicaid eligibility determinations took too long, and unnecessarily delayed care.

There is also a way that Medicaid could begin services when they are needed. The state would perform all intake activities specified in the approved waiver. If the only thing they are waiting for is the determination of disability (and they should have a pretty good idea how this will turn out), they could immediately begin to provide Medicaid services (including waiver services) to the child. The catch: No FFP would be available until the child is determined to be Medicaid eligible. At that time, a retroactive claim could be generated. In adopting this approach, the state would be placing itself in some financial risk, but the state would also be in a position to know just how much risk it is taking on.

The second question dealt with whether a person who is enrolled in a managed care waiver (section 1915(b)) could also enroll in a HCBS 1915(c) waiver. Two states (from 2 different regional offices) had been told that this was not possible. This is incorrect. There is nothing in Federal law or regulation that would permit a person from enrolling simultaneously in both waivers. We even have some waivers that are approved under both sections 1915(b) and (c). The only time that a person would not be eligible to enroll in a HCBS waiver because he/she is served in a 1915(b) waiver would be when the managed care plan in which the individual is enrolled is contractually obligated to provide the waiver services that are otherwise offered only under 1915(c). In this case, a duplication of payment would occur if the individual were to receive services under 1915(c) for which payment is already being made under 1915(b).

The third question came in the evaluation report. It concerns the design of services to be furnished under a waiver (not specified if this is 1915(b), (c) or a combination), and using a capitated payment methodology. We would need more specifics from the state before we could answer this question. Conceptually, it seems like a plausible idea, but the devil is in the details.