Appendix II - Enrollment and Expenditure Projections

Appendix III - Stakeholder Meeting Questions and Answers

Appendix IV - Abbreviated Public Notice

Appendix V – Public Notice

Appendix II - Enrollment and Expenditure Projections

1115 Waiver Population	SFY 2017 (7/1/16 - 6/30/17)	SFY 2018 (7/1/17 - 6/30/18)	SFY 2019 (7/1/18 - 6/30/19)	SFY 2020 (7/1/19 - 6/30/20)	SFY 2021 (7/1/20 - 6/30/21)	Average Trend SFY 2017 - SFY 2021
Demonstration Population Enrollment (Enrollees)	1,000	1,000	1,000	1,000	1,000	0.0%
Demonstration Population Expenditures	$ 12,628,628	$ 12,162,969	$ 12,536,136	$ 13,450,884	$ 14,302,181	3.2%

Appendix III - Stakeholder Meeting Questions and Answers

1115 Waiver Stakeholders Questions, Comments, and Responses
August 27 meeting

1. **How does the waiver interface with the Excellence in Mental Health Act (EMHA)?**

   Response:
   How the 1115 waiver interfaces with the EMHA demonstration project is largely unknown at this point. Waiver payment processes could potentially be included in EMHA payments, or be kept separate. As both projects proceed in development the Department will assess how they interact with each other.

2. **Can other funds such as local tax dollars, mil tax dollars be used as state match?**

   Response:
   The Department is open to consideration of other potential sources of state match for waiver payments outside of traditional general revenue appropriations. Providers who have potential local sources of state match should contact the Department so the fund source can be assessed for applicability. Since the Department requires budget authority to utilize local tax dollars, we are requesting that providers with potential local sources of state match for waiver services contact us no later than December 31, 2015.

3. **Need to review a recent housing advisory issued by CMS to inform waiver development.**

   Response:
   The Department appreciates this comment and has reviewed the CMS Informational Bulletin related to Coverage of Housing Related Activities and Service for Individuals with Disabilities. The Bulletin does not allow the states to pay for room and board. The bulletin clarifies the circumstances under which Medicaid reimburses for housing related activities. For example, under an 1115 waiver, states can provide services to individuals already in the community, by helping the individual problem solve, advocate with landlords, access community resources to assist with back rent, and assist individuals to complete forms for subsidized housing.

4. **Will the waiver be statewide?**

   Response:
   Yes, the waiver will be available statewide. One entry point (CMHL) is available in all service areas. At this time the other entry point (ERE) is available in seven (7) regions serving approximately 75% of the state population. We are considering expanding the ERE project to include additional regions. Further, a request was made at the first

Stakeholder meeting to consider additional hospital based programs to be entry points along with the seven ERE funded sites, and that request is under consideration.

5. **We have had a team interfacing with a hospital ER prior to the seven ERE sites funded through the Strengthening Missouri's Mental Health System initiative. Can you consider including these programs too as entry points into the waiver? Don't exclude hospital teams just because they are not funded through the ERE appropriation.**

   Response:
   The Department is assessing whether to expand the number of entry points into the waiver. However, expanding entry points and potential eligible enrollees will be part of the discussion of trade-offs regarding persons served, eligibility requirements, and benefits packages.

6. **If a person qualifies clinically, should it matter how they are identified? Sometimes persons who otherwise would be CMHL or ERE come in after hours through ACI. Can they still be considered?**

   Response:
   The Department began this planning process by looking at a broader range of entry points into the waiver but given limited initial funding, decided to use the CMHL and ERE projects as the two entry points. Several comments have been made and questions asked about expanding the entry points. The Department will take those comments under consideration in the discussion about trade-offs on clients, eligibility, and benefits.

7. **Is the waiver related to Medicaid expansion efforts in the state? Why are we going with 150% poverty rate for waiver eligibility instead of the ACA coverage rate?**

   Response:
   The waiver is not related to Medicaid expansion in Missouri. We are starting out with a proposal to cover waiver clients up to 150% of the federal poverty level, but we expect that to be a discussion item with CMS in our informal talks with them, and it could be adjusted as the waiver development continues.

8. **If Medicaid expansion happens in Missouri while the waiver is operational, what happens to the waiver? Does it go away?**

   Response:
   The waiver could go away if Medicaid expansion is achieved in Missouri in future years. However it is too early to tell. It would depend in large part on what Medicaid expansion in Missouri ultimately looks like, and what the final waiver eligibility and benefits are.

9. **Will there be slots by region or service area and if so how will they be determined?**

   Response:
   We do not know at this point whether we will have slots and wait lists in this waiver, nor how we would determine slot distribution. We expect that to be a discussion item with CMS. In a similar situation the state of Virginia initially had slots and wait lists approved by CMS, but when their waiver conditions were amended, the slots and wait lists were removed. We intend to explore how and why this occurred with CMS.

10. **Billing issues need to be resolved, for example with ACT and IPS services.**

    Response:
    We will be exploring a number of billing issues as we further develop the benefits package, service definitions, and billing guidelines for waiver services.

11. **Why are we starting at age 19 and not 18, and what exactly does Medicaid cover for persons age 18?**

    Response:
    The Department is proposing to begin coverage for waiver clients at age 19 for several reasons. There are other avenues of Medicaid coverage for 18 year olds through regular Medicaid and CHIP. That coverage is also likely to be a more generous service package than the 1115 Waiver will be able to cover. As waiver funding is limited and the match for the entire service package (physical and behavioral health) must be provided by DMH, it seems to make more sense to not have 18 year olds in the waiver. Another reason is that 18 year olds must receive EPSDT benefits, which are broad-based and expensive, unless CMS would grant a waiver from the federal EPSDT requirements, which is very unlikely. This EPSDT issue will also impact 19 and 20 year olds. While the Department is initially proposing to cover 19 and 20 year olds, we may end up starting waiver eligibility at age 21 because of the cost implications associated with EPSDT requirements. That issue will be looked at closely and will be one focus of informal discussions with CMS.

12. **Don't target the DLA-20 cutoff towards extremely disabled persons; keep it high enough so we can work with persons who are not permanently disabled yet.**

    Response:
    The Department agrees with this comment. Since a focus of the Waiver is to intervene early and provide treatment and supports so persons do not become permanently disabled, the DLA-20 score required for eligibility will take into account that persons who would benefit from the waiver may still be scoring fairly high on the DLA-20 scale.

13. **Recommend looking at and using DLA-20 sub-scales to target waiver services towards those most appropriate and needy.**

    Response:
    The Department agrees with this comment, and the implementation team has already started looking at which DLA-20 sub-scales would be appropriate to be part of the eligibility determination.

14. **Are there any limitations to how long a person can be in the waiver? Is their eligibility limited to 12 months?**

    Response:
    There are no time limitations for enrollment in the waiver, as long as the person continues to meet the eligibility requirements at the time of the annual eligibility re-determination. We expect the length of time a person will be served in this waiver will vary from one person to another based on a variety of factors.

15. **We have long waits in areas of the state to get Medicaid eligibility applications processed and approved, how will this be handled for waiver clients?**

    Response:
    The Department will be working with DSS-Family Support Division (FSD) to create a streamlined process to facilitate a rapid application and approval for waiver clients to gain Medicaid eligibility. This process will likely involve having all waiver Medicaid applications routed to a single FSD county office with staff trained in the waiver.

16. **Some CMHCs have FSD staff on-site to assist in taking Medicaid applications; can they be utilized in the waiver application process? Could they actually process and approve waiver applications?**

    Response:
    The Department and FSD will evaluate these scenarios and determine the best way to use these FSD staff stationed on-site at several CMHC's to facilitate the process for waiver Medicaid applications.

17. **Will there be any time limit set on how long after a referral is made by CMHL or ERE that the person must be enrolled in the waiver? With many clients outreach efforts can take a lot of time.**

    Response:
    There is no time limit planned at this time. We understand that the outreach and engagement with services process will vary from one person to another.

18. **What happens with catchment areas when clients are transient, can multiple providers be involved with a waiver client?**

    Response:
    Multiple providers may be involved with delivering services to a waiver client, as long as the services are coordinated, necessary, and not duplicative.

19. **Are people still enrolled in the waiver when they switch service providers? Does the money follow the person when they move?**

    Response:
    Once a person is determined eligible for the waiver, and they move from one geographical area to another, they are still in the waiver and the money follows them.

20. **When a person turns 36, are they are out of the waiver completely?**

    Response:
    Yes. On their 36th birthday a person served in the waiver will no longer be eligible. As persons age out of the waiver it is expected they will transition to other programs as appropriate.

21. **How exactly will the waiver interface with Vocational Rehabilitation (VR)?**

    Response:
    Since gaining employment and pursuing educational opportunities is a significant focus of the waiver, it is expected there will continue to be close collaboration between the Department, CMHCs, and Missouri Vocational Rehabilitation.

22. **Why would we fund certain employment services through the waiver as opposed to having VR serve them? Could VR make accommodations to make this population eligible?**

    Response:
    Missouri Vocational Rehabilitation has federal requirements regarding eligibility for services and is not an entitlement program like Medicaid. Individuals must have an eligible disability and functional limitations to employment that the agency can assist with addressing with an individualized plan. DMH has current payment mechanisms to fund services that support an individual finding and maintaining employment, such as Community Support Services, Assertive Community Treatment and Psychosocial Rehabilitation.

23. **We need to think about how to pay for outreach and engagement.**

    Response:
    The Department understands that the process of engaging persons referred for the waiver is critical, and will explore a mechanism to pay for this.

24. **Can some benefit categories be included, but limited to keep costs down? Optical and dental benefits both should be covered. It is important for persons applying for jobs and interviewing to have good dental hygiene, hard to make a good impression with bad teeth.**

    Response:
    The Department agrees that dental and optical services would be beneficial for waiver clients. Whether they will be included in the waiver is still to be determined as the cost of the service package is evaluated. Covering certain services but limiting the extent of the benefit will be considered to control costs.

25. **Dental may be more important to cover than optical since there are other resources out there to help persons with optical needs.**

    Response:
    The Department agrees that, to the extent to which a potential waiver benefit can be provided through other resources that should be a factor in determining what to cover with limited funding.

26. **Several comments were made regarding NEMT (non-emergency medical transportation): 1. NEMT isn't effective and timely in some areas of the state and we just don't use it, so it should not be a priority. 2. NEMT might be a better way of helping persons access medically necessary services as opposed to paying CSSs, particularly in rural areas.**

    Response:
    The Department understands that there are varying points of view across providers and regions on the effectiveness of NEMT services. These will be taken into account when determining whether to include NEMT as a covered benefit for waiver clients. If NEMT is covered, however, it is a PMPM (per member per month) payment, so there would be a cost to cover all waiver enrollees, regardless of whether they use NEMT or not.

27. **It is not clear how employment related services are delivered in the waiver. Need to address job development and other elements for IPS.**

    Response:
    The Department is working on a clear description of how employment related services are provided, and by whom, for waiver clients. Not all clients will need the IPS level of

services. There are multiple existing billing codes that allow for assisting clients in gaining the outcome of competitive integrated employment. DMH is exploring additional billing codes specifically for job development and job coaching which are not current Medicaid covered services in CMHCs.

28. **All interventions provided under the RAISE/NAVIGATE models need to be covered services in the waiver.**

    Response:
    The Department agrees. The RAISE/NAVIGATE models are critical tools for effectively serving young adults facing their first major mental illness episode, and those service components will need to be available to bill for under the waiver to the extent possible.

29. **Missouri's outcomes for employment are poor so this must be a particular focus in a waiver for young adults.**

    Response:
    The Department agrees that overall employment outcomes for the SMI population in Missouri are low; around 13%. Individualized Placement and Support supported employment programs and Assertive Community Treatment for Transition Aged Youth using the Supported Employment and Education RAISE model have shown great success with employment outcomes, ranging from 25% to 68% working in IPS programs. Improving employment outcomes will be a focus of this Waiver.

30. **Will billing unit issues be addressed? Currently we have a lot of survivors of trauma in childhood and PTSD, but are limited by billing rules to a 60 minute session, when 90 minute sessions are often required.**

    Response:
    The Department will look at billing unit issues such as this when developing the catalog of services and covered benefits for the waiver. Our goal is to create service definitions that meet the particular needs of this young adult population.

31. **We need to focus more on therapy with this population and less on some traditional community support interventions. And don't limit providers of different kinds of therapies such as OT, etc. With the states focus on evidenced based practices and trauma, we should have broad definitions around types of therapy that can be utilized. Need to be able to implement best practices.**

    Response:
    The Department agrees that various types of services would be beneficial for waiver clients. Whether they will be included in the waiver is still to be determined as the cost of the service package is evaluated. Covering certain services, but limiting the extent of the benefit will be considered to control costs.

32. **We should focus on serving fewer clients, but with a stronger benefits package if we want to achieve real outcomes.**

    Response:
    This comment gets to a critical issue in the development of the waiver. Balancing the desire to serve as many eligible persons as possible with a strong package of physical and behavioral health services versus the limitations on funding to get the program started, will be an important discussion going forward as we move closer to finalizing eligibility requirements and the benefits package. The demonstration aspect of the waiver and the evaluation piece will require the achievement of identified outcomes.

33. **Persons on the lower end of the 19-35 population often have relatively intact family structures and support; they may not have burned all their bridges at this point as opposed to older persons, so allow us to work with those family members too and bill for it. Need to be able to reinforce natural support systems while they are still relatively intact.**

    Response:
    The Department agrees with this comment. The ability to work with family members and the current support structure for waiver clients is critical to achieving good outcomes. We will evaluate where and how these activities can be funded.

34. **Will we consider wrap-around payments in the waiver? Sometimes we provide something simple like a new pair of shoes for a person going to a job interview, or allowances for cell phones; hopefully we will have some way to access wrap-around funding.**

    Response:
    The Department agrees that funding for wrap-around services is important for this population. However, it is highly unlikely these types of payments could be incorporated as a Medicaid reimbursable service, even under an 1115 demonstration waiver. We will evaluate what is the most appropriate method to pay for wrap-around services for waiver clients.

35. **We need to help persons learn, and reinforce social skills, and communicate with them the way young adults communicate, with computers, social media applications, etc. and get paid for that. The case management/community support procedure codes should reimburse for electronic based contacts with waiver clients. Many young persons prefer text messaging to phone calls or even home visits.**

    Response:
    The Department agrees that communication strategies targeted to young adults, including their preferences, should be evaluated. DMH and MO HealthNet have been in

discussions for some time regarding the appropriateness of reimbursing electronic-based contacts with Medicaid recipients.

36. **What happens when a provider who doesn't have a CSTAR contract has a waiver client with SUD and SMI?**

    Response:
    Providers are expected to make appropriate referrals for waiver clients who are determined to need other services not provided through their contracts with the Department. Care should be coordinated between providers when multiple services are needed.

37. **We need a procedure code to reimburse for crisis intervention that is available in different settings including ERs and crisis stabilization centers.**

    Response:
    Crisis intervention is currently being proposed as a covered service under the waiver. We need to evaluate the settings in which this service should be delivered in the waiver.

38. **What are the diagnostic criteria for SMI and SUD for the waiver?**

    Response:
    The proposed diagnostic criteria for Waiver eligibility is a large subset of current diagnostic criteria for admission to CPR and CSTAR programs. The specific proposed diagnoses were sent to the stakeholders group following the first meeting and will be discussed further at the second meeting on September 23.

39. **On the Waivers Requested section, #1, in the CMS Concept Paper, what exactly does the Retroactive Eligibility section 1902(a) (34) mean?**

    Response:
    Under Medicaid rules, individuals typically are eligible for coverage of services up to three months prior to when they apply. Several states have requested and received this waiver, including Virginia. It is generally requested as a cost-saving mechanism that helps the state cover more people and that was likely the rationale in Virginia. As the waiver development proceeds we anticipate discussing this further to make a final determination on whether we want a waiver from this section.

1115 Waiver Stakeholders Questions, Comments, and Responses
September 23 meeting

1. **Several persons asked why the Access Crisis Intervention (ACI) system is not being proposed as a point of entry into the 1115 Waiver, and why the entry points were limited to the CMHL and ERE programs. It was stated that limiting the entry points to CMHL and ERE could create adverse incentives whereby individuals try to access the waiver by using those two entry points inappropriately.**

   Response:
   The Department originally received approval from the Governor's office and the General Assembly to move forward with developing an 1115 Waiver on the basis of using only CMHL and ERE as the entry points. The Department understands there could be adverse incentives with using just these two programs as entry points into the Waiver and will work with providers to insure this does not occur. In addition, the limited funding available to support the waiver would not allow for a larger broad based client population identified through ACI to be served in the Waiver. As funding becomes available for additional ERE projects the Department will add those regions as Waiver entry points.

2. **One person questioned if we are missing the original intent of the waiver which was to intervene with individuals early in the progression of their illness near the time of their first episode, and suggested the Department consider a tier system with a mix of CMHL/ERE and possibly some ACI individuals who meet the original intent of early intervention.**

   Response:
   The original intent of the Waiver was to provide a path for uninsured young adults age 19-35 identified through the CMHL and ERE crisis programs to obtain Medicaid eligibility and access a targeted benefit package of physical and behavioral health services. Many of those persons are relatively early in their illness progression, although that will vary from one person to another. The Department will consider how to develop eligibility guidelines to prioritize persons applying to the Waiver, which could result in a tiered system based on an assessed level of need. The Department is reluctant, for reasons described in #1, to open Waiver eligibility to persons identified through ACI at this time. As funding becomes available for additional ERE projects the Department will add those regions as Waiver entry points.

3. **One person questioned why Assertive Community Treatment (ACT) was part of the proposed benefits package, stating that by the time an individual qualifies for an ACT team they are already permanently and totally disabled (PTD), and thereby not the focus of an early intervention waiver.**

   Response:
   The Department is proposing that Waiver clients be able to access both traditional ACT teams and the newer Transitional Age Youth (TAY) ACT teams, as appropriate. Since employment is a key goal of the Waiver, we believe that accessing the employment specialist on both types of ACT teams would be an appropriate benefit to help achieve employment goals. Some persons who access traditional ACT team are still relatively early in their illness progression, and we are not inclined to draw a firm line as to where someone is in their illness progression in the context of Waiver eligibility.

4. **One person questioned why employment services were part of this Waiver and suggested Vocational Rehabilitation (VR) should be at the table and provide the employment services needed by this population so the limited dollars could be spent on other parts of the benefits package. Another person agreed that VR should be at the table and coordinating with the Department, but questioned how many persons in this Waiver would meet VR's eligibility (order of selection) criteria. Another person supported VR working with as many Waiver clients as they can under their guidelines.**

   Response:
   Differing comments were received regarding how DMH should coordinate employment services and supports with VR. Since not all Waiver clients will meet VR eligibility requirements, the Department believes the best approach is to individually assess each persons needs in the employment area, utilize VR supports when appropriate, and utilize supports though CMHC's where appropriate, coordinating between the two entities to avoid duplication and insure the person gets access to the employment supports that fit best for them.

5. **One person stated that inpatient hospital costs are an important factor and asked if the Department has looked at hospitalization and diversion rates for the specific persons being identified in the CMHL and ERE programs.**

   Response:
   The Department agrees that inpatient costs are an important factor. We have not looked specifically at hospitalization and diversion rates for CMHL clients. The Department has data on ERE clients that indicate significant decreases in both ER visits and hospitalization. At this point the Department believes both inpatient and ER will not be covered services under the Waiver.

6. **One person stated the ACI system has benefitted greatly from the ERE project, but is concerned that diversion rates could start going down if persons are incentivized to use ER's to gain access to Waiver eligibility.**

   Response:
   As stated previously, the Department is interested in working with providers to insure persons do not utilize services such as ER inappropriately just to become eligible for the Waiver. Diverting persons from using ER's is also a goal of the ERE project and persons diverted will be eligible for Waiver enrollment.

7. **One person stated the Waiver needs to be focused on early intervention, as persons with higher needs will use more of the scarce resources and fewer persons will be able to gain access to the Waiver.**

   Response:
   The Department agrees that a major focus of the Waiver will be on early intervention, and persons later in their illness progression tend to have higher needs and would likely use our limited resources at a higher rate. However, we are not inclined to draw a firm line as to how early in their illness progression a person has to be in order to be admitted to the Waiver. We intend to provide general guidelines in this area for providers to use when considering a referral to the Waiver for young adults identified through CMHL and ERE. We believe persons in this age range, even if they have been struggling with SMI and/or SUD for longer periods of time than others, can still be positively impacted by access to the benefits package and achieve significant outcomes in the area of employment and other demonstration goals.

8. **One person stated the list of proposed services looks good, but would like to see expanded definitions to be sure, and suggested that definitions be written with flexibility, such as providing for group interventions as appropriate.**

   Response:
   The Department agrees with this comment. We are developing a services catalog for the Waiver application and the system redesign necessary at both MO HealthNet and DMH. The service definitions will be flexible to meet the unique needs of the Waiver population, and will include several types of group interventions.

9. **One person asked for clarification on what Medicaid claims data Mercer is working from.**

   Response:
   The Department is providing Mercer with Medicaid claims data for the past five (5) complete calendar years, 2010-2014, for persons meeting the proposed Waiver eligibility requirements, i.e., age 19-35 and with an SMI and/or SUD diagnosis.

10. **One person suggested that the Waiver application be written so that local providers have the ability to make their own tough decisions on what road to take to get persons admitted.**

    Response:
    In order to get an 1115 Waiver application approved, we must be very specific about the entry points, benefits, eligibility criteria, and process for getting clients admitted to the Waiver. This will result in less flexibility than providers are used to when providing services in Department funded programs.

11. **One person asked if the DLA-20 can be used to assess the level of need of persons being identified through the ACI system so some of those individuals can gain access to the Waiver.**

    Response:
    The DLA-20 will be used to assess level of need for persons identified through the CMHL and ERE entry points. As described earlier, the Department will not be using the ACI system as an entry point into this Waiver.

12. **One person advocated for the inclusion of personality disorders (specifically borderline and antisocial) and Obsessive Compulsive Disorder in the list of waiver eligible diagnoses, stating they can be very debilitating and are often paired with another diagnosis. Another person said their agency has a large number of persons with borderline personality disorder and asked if other agencies are seeing that as well, and suggested the Department look closer at this population for waiver eligibility. Another person questioned why Schizophrenia, Catatonic Type was a proposed diagnosis for Waiver eligibility, and suggested the Department take another look at the proposed diagnostic eligibility criteria to see that it is appropriate to the proposed population of 19-35 year olds needing early intervention. Another person questioned why Major Depression-Recurrent was being proposed for waiver eligibility when persons with that diagnosis were likely to be further downstream and not as appropriate for early intervention. Another person stated that including Major Depression-Single Episode would be appropriate for a program focusing on early intervention. Another person questioned why the Department does not just make the waiver diagnoses consistent with current CPRC and CSTAR diagnostic criteria.**

    Response:
    The Department took all the suggestions for expanding the diagnostic eligibility requirements for Waiver admission under consideration following the last stakeholder meeting. Primarily due to concerns about opening up Waiver eligibility beyond the availability of the initial limited funding, we are not inclined to add additional diagnoses to the Waiver eligibility at this time. We will keep these comments under advisement as we implement the Waiver and will consider expanding the diagnoses at a future date.

13. **One person asked what the expected caseload size would be for a CSS (Community Support Specialist), noting that the time a CSS would have to work on employment issues would depend on the caseload size.**

    Response:
    The Department will take this comment under advisement as we develop definitions for Waiver services.

14. **One person asked that employment specialists and job coaches be included in the definition of eligible providers for the employment supports service.**

    Response:
    The Department agrees with this comment and intends to define eligible providers of the Employment Supports service to include Community Support Specialists, Peer Specialists, and Employment Specialists and Job Coaches as eligible providers of the service.

Appendix IV - Abbreviated Public Notice

Public Notice

The Missouri Department of Social Services (DSS), in partnership with the Missouri Department of Mental Health (DMH), hereby notifies the public of its intent to submit a written application to request a Section 1115 Research and Demonstration waiver for the Mental Health Crisis Prevention Project. A copy of the full public notice document and the demonstration application under consideration may be found at http://dss.mo.gov/mhd/ . We are providing this notice pursuant to Centers for Medicare & Medicaid Services (CMS) requirements in Title 42, Section 431.408, Code of Federal Regulations.

The 1115 Waiver for the Mental Health Crisis Prevention Project is designed to provide early intervention, treatment and community support services to Missourians aged 21 to 35 with income levels at or below 150 percent of the Federal Poverty Level who are identified through a behavioral health crisis.

Public Comments and Hearings

The public is invited to review and comment on the State's proposed demonstration waiver request. It can be viewed at http://dss.mo.gov/mhd/ . The public may also request a copy of the application by calling the DMH Division of Behavioral Health at 573-751-9499.

Written comments postmarked on or before March 25, 2016 or email submitted until midnight on March 25, 2016 will be accepted. Comments may be sent to the following address:

MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500
Attn: MO HealthNet Director
Email: Ask.MHD@dss.mo.gov

Public Hearings

There will be six public hearings in which the public is invited to comment on the 1115 Waiver Demonstration for the Mental Health Crisis Prevention Project application. The Public Hearings are scheduled:

March 10, 2016, 3:00-5:00 p.m.
Mark Twain Behavioral Health
917 Broadway
Hannibal, MO 63401
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 11, 2016, 9:00-11:00 a.m.
Community Counseling Center
402 S. Silver Springs Road
Cape Girardeau, MO 63703
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 11, 2016, 2:00-4:00 p.m.
BJC Behavioral Health
BJC Learning Institute, LL Conference Room C
8300 Eager Road
St. Louis MO 63144
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 17, 2016, 2:00-4:00 p.m.
Missouri Coalition for Community Behavioral Healthcare
221 Metro Drive
Jefferson City, MO 65109
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 18, 2016, 9:00-11:00 a.m.
Burrell Behavioral Health
1300 E. Bradford Parkway
Springfield, MO 65804
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 18, 2016, 3:00-5:00 p.m.
ReDiscover
901 NE Independence Ave.
Lee's Summit, MO 64086
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

Verbal or written comments will be accepted at the public hearings. Complete copies of the 1115 Waiver Demonstration for the Mental Health Crisis Prevention Project application will be available at the public hearings. The outcome of this process and the input provided will be summarized for CMS upon submission of the demonstration application. The summary of comments will be posted for public viewing at http://dss.mo.gov/mhd/ along with the waiver application when it is submitted to CMS.

Appendix V – Public Notice

Public Notice

The Missouri Department of Social Services (DSS) is providing public notice of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) a written application to request approval of a Section 1115 Research and Demonstration waiver and to hold public hearings to receive comments on this proposal. We are providing this notice pursuant to CMS requirements in Title 42, Section 431.408, Code of Federal Regulations.

DSS, through its MO HealthNet Division and in partnership with the Missouri Department of Mental Health (DMH), is seeking a five-year Medicaid Section 1115 Research and Demonstration waiver (hereinafter "demonstration" or "demonstration application") for the Mental Health Crisis Prevention Project which is designed to provide early intervention, treatment and community support services to Missourians aged 21 to 35 who are identified through a behavioral health crisis. The overall goal of this demonstration is to identify young adults in crises, extend Medicaid eligibility with a targeted benefit package, and engage individuals in services that start them on the path to recovery.

Program Description and Goals

The proposed demonstration builds upon two successful programs implemented as part of Governor Nixon's Strengthening Missouri's Mental Health System Initiative. These programs – the Community Mental Health Liaison program and the Emergency Room Enhancement program – identify young adults who are experiencing a behavioral health crisis and link them to health care and behavioral health services. Under the proposed demonstration, individuals identified through these programs will have far greater access to integrated medical and behavioral health services, including evidence-based supported employment services. More specifically, the goals of the demonstration are to:

- Improve access to health care for a segment of the uninsured population in Missouri who have significant medical and behavioral health needs;
- Improve the physical and behavioral health outcomes of demonstration participants, thereby delaying or reversing the progression toward disability; and
- Improve the education and employment outcomes of demonstration participants by creating a pathway toward independence.

Once approved, the demonstration will be statewide and will operate for a period of five years. Missouri proposes to implement July 1, 2016, and operate the waiver through June 30, 2021, or until Missouri implements a broader expansion of Medicaid that would otherwise make this population of adults eligible for coverage under the State Plan.

Beneficiaries and Eligibility Criteria

For this demonstration, Missouri proposes to target individuals who meet the following eligibility parameters. Individuals must meet all of the requirements outlined below to be eligible for the demonstration:

- Referred through the Community Mental Health Liaison (CMHL) or the Emergency Room Enhancement Program (ERE) with a serious behavioral health crisis;
- Determined to have and need treatment for a serious mental illness (SMI) and/or substance use disorder (SUD) as defined by the Department of Mental Health;
- At the time of application, need for treatment requires a total Daily Living Activities (DLA) GAF/mGAF score of 50 or below for both serious mental illness and/or substance use disorder;
- Adult ages 21 to 35 years old;
- U.S. Citizen or eligible qualified legal immigrant;
- Not eligible for any state or federal full benefits program including: Medicaid, Children's Health Insurance Program (CHIP), or Medicare;
- Resident of Missouri;
- Gross income of the individual that is at or below 150% of the Federal Poverty Level (FPL);
- Uninsured; and
- Not residing in a long term care facility, mental health facility, long-stay hospital, intermediate care facility for persons with developmental disabilities, or penal institution.

Benefit Package, Delivery System and Cost Sharing

Missouri is proposing a targeted package of behavioral health and physical health services targeted to young adults with SMI and/or SUD. The proposed benefit package was designed with input from key stakeholders and knowledgeable experts and includes services that best support effective treatment and early intervention for the target population. The services include selected outpatient, non-emergency department based physical and dental health care benefits[1] and a comprehensive set of outpatient, non-residential behavioral health care benefits. Supported employment that includes job development and job coaching is a new service being proposed under the waiver that is designed to move people into education or employment in order to create stable foundations for ongoing recovery, a pathway toward independence, and a path *away* from future disability.

Services will be provided through a fee-for-service delivery system. Cost sharing requirements are no different from those under the Medicaid State Plan.

Anticipated Enrollment and Expenditures

[1] Inclusion of dental benefits is pending approval of SPA #16-01, submitted January 6, 2016, anticipated effective date January 1, 2016.

Missouri anticipates that approximately 1,000 individuals can be served at any point in time during the demonstration. Projections of the duration individuals will remain in the waiver indicate that approximately 1,900 individuals can be served over the five year course of the demonstration. To the extent additional state funding becomes available, the state may be able to expand enrollment.

Below is the projected enrollment and expenditures for the five year demonstration.

1115 Waiver Population	SFY 2017 (7/1/16 - 6/30/17)	SFY 2018 (7/1/17 - 6/30/18)	SFY 2019 (7/1/18 - 6/30/19)	SFY 2020 (7/1/19 - 6/30/20)	SFY 2021 (7/1/20 - 6/30/21)	Average Trend SFY 2017 - SFY 2021
Demonstration Population Enrollment (Enrollees)	1,000	1,000	1,000	1,000	1,000	0.0%
Demonstration Population Expenditures	$ 12,628,628	$ 12,162,969	$ 12,536,136	$ 13,450,884	$ 14,302,181	3.2%

Hypotheses and Evaluation of the Mental Health Crisis Prevention Project

The demonstration will test the following hypotheses:

- Early intervention with young adults experiencing a behavioral health crisis, including enrollment for a minimum of one year in an evidence-based program of health coverage that coordinates primary and behavioral health care, will result in fewer Emergency Department (ED) visits for participants.
- Early intervention with young adults experiencing a behavioral health crisis, including enrollment for a minimum of one year in an evidence-based program of health coverage that coordinates primary and behavioral health care, will result in fewer Social Security disability determinations, which often lead to full Medicaid eligibility.
- Early intervention with young adults experiencing a behavioral health crisis, including enrollment for a minimum of one year in an evidence-based program of health coverage that coordinates primary and behavioral health care, will increase the likelihood of maintaining or gaining competitive integrative employment.
- Early intervention with young adults experiencing a behavioral health crisis, including enrollment for a minimum of one year in an evidence-based program of health coverage that coordinates primary and behavioral health care, will reduce arrests by law enforcement.
- Early intervention with young adults experiencing a behavioral health crisis, including enrollment for a minimum of one year in an evidenced-based program of health coverage that coordinates primary and behavioral health care, will increase the likelihood of stable housing.
- Early intervention with young adults experiencing a behavioral health crisis, including enrollment for a minimum of one year in an evidenced-based program of health coverage that coordinates primary and behavioral health care, will increase the likelihood of remaining in school or finding and participating in an academic program of choice.

These hypotheses will be evaluated by measuring the ED visit rate, Social Security Disability Determination rate, employment rate, arrest rate, private resident living rate/homeless rate, and the rate of involvement in academic programs for demonstration participants.

Waiver and Expenditure Authorities

Missouri requests, under the authority of Section 1115(a)(2) of the Social Security Act, that expenditures made by Missouri for the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act, shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan.

Expenditures for a targeted benefit package for the population eligible for services under the demonstration. Expenditures for coverage of health care services for individuals aged 21 through 35, with income up to and including 150 percent of the FPL, who have been identified through the state's Emergency Room Enhancement project or Community Mental Health Liaison Program, who have a serious mental illness and/or substance use disorder as determined by the Department of Mental Health, who have met level of care criteria as determined by the Department of Mental Health, but who are otherwise ineligible for Medicaid based on income.

To the extent necessary to implement the proposal, the demonstration application requests that CMS, under the authority of section 1115(a)(1) of the Social Security Act (42 USC 1315), waive the following requirements of Title XIX of the Social Security Act (42 USA 1396) to enable the State of Missouri to implement the Mental Health Crisis Prevention Project.

Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to offer a reduced/modified benefit to populations eligible under the demonstration.

Reasonable Promptness **Section 1902(a)(8)**

To enable the state to modify eligibility thresholds in order to maintain enrollment up to the limit established in budget neutrality.

Methods of Administration – Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To allow the state, to the extent necessary, to not provide non-emergency transportation to and from providers for participants.

Comparability **Section 1902(a)(17)**

To the extent necessary to enable the state to vary income requirements and impose clinical eligibility criteria for individuals to which they otherwise would not be subject under the state plan.

Public Notice and Input

The complete draft of the demonstration application is available for public review at http://dss.mo.gov/mhd/. The public may also request a copy of the application by calling the DMH Division of Behavioral Health at 573-751-9499. Written comments postmarked on or before March 25, 2016 or email submitted until midnight on March 25, 2016 will be accepted. Comments may be sent to the following address:

MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500
Attn: MO HealthNet Director
Email: Ask.MHD@dss.mo.gov

The State will host six public hearings during which the public is invited to comment on the 1115 demonstration for the Mental Health Crisis Prevention Project application. To ensure statewide accessibility, the public hearings are being held in different geographic locations around the state and each hearing will also allow telephonic participation by the public. The schedule for the public hearings is:

March 10, 2016, 3:00-5:00 p.m.
Mark Twain Behavioral Health
917 Broadway
Hannibal, MO 63401
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 11, 2016, 9:00-11:00 a.m.
Community Counseling Center
402 S. Silver Springs Road
Cape Girardeau, MO 63703
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 11, 2016, 2:00-4:00 p.m.
BJC Behavioral Health
BJC Learning Institute, LL Conference Room C
8300 Eager Road
St. Louis MO 63144
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 17, 2016, 2:00-4:00 p.m.
Missouri Coalition for Community Behavioral Healthcare
221 Metro Drive
Jefferson City, MO 65109
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 18, 2016, 9:00-11:00 a.m.
Burrell Behavioral Health

1300 E. Bradford Parkway
Springfield, MO 65804
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

March 18, 2016, 3:00-5:00 p.m.
ReDiscover
901 NE Independence Ave.
Lee's Summit, MO 64086
Public may call 1-866-906-9888, PIN# 9841665 for teleconference

Verbal or written comments will be accepted at the public hearings. Complete copies of the 1115 Waiver Demonstration for the Mental Health Crisis Prevention Project application will be available at the public hearings. The outcome of this process and the input provided will be summarized for CMS upon submission of the demonstration application. The summary of comments will be posted for public viewing at http://dss.mo.gov/mhd/ along with the waiver application when it is submitted to CMS.