

The Coordinated Services Team Initiative

Guide to Financial Sustainability of Collaborative Systems of Care for Tribes

For more information on collaborative systems of care in Wisconsin, please contact:

White Pine Consulting Service, Inc.
N3000 Rusch Road
Waupaca, WI 54981
(715) 258-5430
whitepine@mwwb.net
www.wicollaborative.org

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*This document was prepared by Sinikka Santala, White Pine Consulting Service, Inc.
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2. Introduction

The provision of health care to American Indians and Alaska Natives falls under the federal trust responsibility, rooted in the United States Constitution, that recognizes the debt owed to Indian tribal governments. With the recognized responsibility to indigenous people has come respect for tribal sovereignty and willingness to work with the tribes on a culturally sound health delivery system. However, a major shortcoming is chronic underfunding that results in under utilization of these programs.

In Wisconsin, Governor Jim Doyle issued Executive Order 39 in 2004 that recognized the unique status of Indian Tribes and their right to existence, self-government and self-determination. The Executive Order also directed the cabinet agencies to recognize the unique legal relationship between the state and the Indian Tribes and directed the agencies to accord to the tribes the same respect accorded to other governments.

The Coordinated Services Team (CST) initiatives operated by Wisconsin tribes are governance-wise, culturally and fiscally different from the CST initiatives operated by Wisconsin counties.

Recognizing the tribal sovereignty, the Department of Health Services, in collaboration with the Department of Children and Families has made CST funding available for tribes to allow them to develop CST initiatives that meet the cultural and programmatic needs of Native Americans.

Several Wisconsin tribes have received five year CST implementation grants. At the writing of this document (February 2011), Lac Courte Oreilles, Lac du Flambeau, Red Cliff, Bad River, and St. Croix Chippewa Tribes have received CST grants to develop the CST initiative. Since the grant funds will eventually end, it is important that the tribal CST initiatives and tribal governments start identifying funding sources to sustain the CST effort starting during the first or second year of the grant.

The purpose of this document is to assist tribal CST Initiative Coordinators and other tribal fiscal and planning staff in identifying potential funding sources for CST sustainability.

Each tribe and tribal CST is unique and an approach that may meet the needs of one tribal CST may not fit well for another tribe.

This document therefore presents a variety of funding options, describes the process to pursue each option and contains reference to several websites for additional detail about the funding options. While the document targets tribes with CST Initiatives, many of the potential funding sources identified may also be of interest to other tribal programs, such as mental health and substance abuse services, Indian Child Welfare and tribal disability services.

This document was prepared with the involvement of two tribal CST Initiatives, Lac Courte Oreilles and Lac du Flambeau, who volunteered as “pilots” to identify potential funding sources best suited for them. The journey of completing the full utilization of funding options identified by each CST is ongoing. However, their willingness to participate in the effort to identify sources for sustainability is deeply valued and appreciated.

3. The Unique Fiscal Opportunities and Challenges of Tribal CST Initiatives

The tribal CST initiatives face several challenges that need to be addressed in their sustainability planning and implementation. Tribal members are also residents of the county(ies) where the tribe is located. Counties have the responsibility for several services, such as mental health, substance abuse, child welfare, and children's long term support that overlap with CST services. Tribes have the option in many service areas to assume the responsibility for the provision of these services to tribal members. Until the tribes assume these responsibilities, it is important for the tribal CST and the county staff responsible for services to children involved in these programs cultivate a collaborative working relationship. Mutual respect, understanding and collaboration will greatly assist the county staff and the tribal staff in providing and sustaining high quality CST services for tribal children and families. However, misunderstandings and unwillingness to collaborate can and will hamper the CST effort. Outside consultation may be necessary to start healing these relationships.

Two sustainability funding sources used most often by county CST initiatives are (a) redirecting some savings from the county out-of-home placement budget achieved by the CST to funding the CST effort, and (b) maximizing certain Medicaid fee-for-service programs, such as Comprehensive Community Services (CCS) and Targeted Case Management (TCM). These programs will be described in more detail later in this document.

Since tribal children are also residents of the county, it is the county, not the tribe that has the fiscal responsibility for out-of-home placement costs. Therefore, savings in out-of-home placement achieved by the tribal CST are realized in the county's budget.

Tribal program managers are often responsible for several different programs, that have different program and reporting requirements. Because of the multiple demands on their time and attention, it is often challenging to be able to devote a significant amount of time to start yet another program effort, such as the establishment of the systems, processes and policies to capture additional funding. For example, Medicaid program rules can be quite complex, and some may require such a large client base that it is not possible to achieve in a tribal setting. Furthermore, it may be difficult for the tribes to establish charting, documenting and billing processes, and employ billing staff resources to capture Medicaid funding. Provision of technical assistance and support to the tribes in maximizing these funding sources is a high priority to the Department of Health Services (DHS).

However, tribal CST initiatives also have some definite advantages. Every tribal health care center is a Federally Qualified Health Center (FQHC) and collaboration with the FQHC holds the potential of achieving Medicaid reimbursement that covers the actual cost of approved services. This arrangement can result in a significantly higher Medicaid payment level for some of the services provided through CST that can be billed to Medicaid.

Furthermore, federal regulations allow 100% reimbursement for Medicaid services provided by tribal providers to Native Americans. This potential funding source holds further promise for stable funding for tribal CST initiatives.

The final challenge is the fact that many of these approaches are new to Wisconsin. While other states, such as Washington and Oregon have taken advantage of these funding sources for years, Wisconsin is in the early stages of developing processes to maximize these resources. However, the commitment to accomplishing this is strong and it has been clearly documented in the DHS/Wisconsin Tribes Consultation Implementation Plan updated in June 2010.

4. Potential Community Resources

A. Collaborative Partners

A collaborative approach views community organizations, whether tribal organizations or other local community groups, as equal partners in wrapping services around children and families. In a true collaborative process, service coordination is a “way of doing business” that is owned by the entire community. Community partners may be sources of support by contributing team facilitators or by contributing to a flexible funding pool. They may also be important liaisons to encourage participation by their peers and to solicit support from community organizations. Schools, law enforcement agencies, and community-based organizations within and outside of the tribe are sources for financial support. Even if collaborative agencies are unable to contribute actual dollars, their willingness to commit staff resources to serving on the community Coordinating Committee, Child and Family Teams and participation in the development and implementation of the Plan of Care for children and families served by CST is an added benefit.

In addition to using Medicaid and other funding to support services, one potential approach for CST sustainability is to involve all tribal agencies in evaluating the outcomes for the children and the families who are served by the tribal CST. The CST has the potential of assisting the entire family to health, thus reducing many costs that the tribal agencies are funding. It may be especially feasible to measure the child’s and his/her family’s reduced use of mental health and substance abuse services, law enforcement and jail services, etc. Improved school attendance or participation in work are examples of other positive indicators. Documenting this improvement to the Tribal Legislature will provide evidence of the effectiveness of CST when requesting funding from the tribal government.

B. Charitable Organizations

Almost all communities have Community Foundations, United Ways or other charitable organizations. CST initiatives should ask about the specific funding priorities of the organizations. Coordinating Committee members may know of funding sources and be good resources to make personal contacts. The more definable, persistent, and visible the CST mission, the easier it will be to attract financial support from both charities and foundations.

Individual churches or faith-based organizations are also possible resources to approach. They may have funding to meet special family needs or might provide services such as transportation. Connecting families with these resources could provide the families with ongoing natural supports.

C. Short-Term Grants

Many tribal governments employ grant writers who have been very successful in identifying various grant resources. The concern about these grants is that they may be limited to “start up” costs or end after a year or two. Also, writing a grant is time intensive. Once a grant is written, however, it may be able to be easily modified for applying funding from other organizations. A short-term grant can be used to do the up front, intensive work to get a program started. For example, Community Options Program (COP) at the Department of Health Services, may have short-term grant funding available to assist in hiring consultants or limited term employees to perform all the upfront work to qualify for Medicaid certification for targeted case-management or other programs discussed below. Menominee Tribe used this approach successfully in becoming a Home and Community Based Medicaid waiver agency serving the elderly.

D. State and Federal Allocations

Recent state budget cuts in state aids seriously impacted the ability to use state allocations to increase funding for collaborative service. These state aids include Community Aids, Mental Health Block Grant, Substance Abuse Block Grant, IV-E Incentive funds and Safe and Stable

Families. Most of these allocations are fixed (but shrinking) amounts and may be committed to other services but could be redirected based on a tribe or county's needs and priorities.

E. Existing Tribal and Community Resources

Effective CST initiatives foster the healing of the children and the families who are served by the CST. Therefore one possible funding source to sustain the CST initiative that should be considered is the existing funding sources controlled by the tribal governments. Making a powerful case using documentation of positive outcomes (i.e. improved school attendance, better grades in school, reduction in juvenile justice involvement, improved mental health, reduction in substance abuse, etc) is a key to making a persuasive case for using tribal funds for CST sustainability.

Community resources available to all children and families can be a way of increasing services available for CST, and integrating the child and family into the community. For example, an after school program for all children might be looked to for a child with a disability. Offering the support of a child and family team, asking the program to make a modification to accommodate the child's needs, or offering to provide additional support until the child is assimilated into the program might be required.

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5. Out-of-Home Placement Savings Invested to Sustaining the CST

As mentioned earlier, Wisconsin counties are financially responsible for the out-of-home placement costs of children in residential treatment facilities, group homes and state mental health institutes. A 2009 state law requiring counties to pay the non-federal share of Medicaid payments when a child/adolescent is hospitalized at Mendota or Winnebago Mental Health Institute has put further pressure on county funds. Many county operated CST initiatives have been able to document significant savings in the county out-of-home placement budget. For example, in one county the 28 children served in the first three years of CST had 17 days of hospitalization compared to 1,289 days prior to the CST. These same children experienced 506 less days in residential care, group homes, correctional facilities and foster care. The savings to this small county in out-of-home placement costs were \$210,000 in the first year (1999) and \$470,713 by the fourth year (2002). These savings can have a major impact on local decision makers and on their willingness to continue funding the CST effort.

Tribal CST initiatives are at a significant disadvantage because their successful efforts to maintain children in out-of-home placements will benefit the county financially, not the tribe. However, through tribe/county collaboration, there may be opportunities even in this challenging situation. For example, one tribal CST that has an excellent working relationship with the county is currently targeting children who are at high risk of out-of-home placement. If the tribal CST is successful in preventing out-of-home placements, the county is willing to consider allocating some of the savings in the out-of-home placement budget to sustaining the tribal CST.

In order for the tribal CST to get funding from the county, two critical pieces must be in place: The county/tribal CST relationship must be collaborative and the tribal CST must achieve savings in the county's out-of-home placement budget.

Another important component to access the out-of-home placement savings is to carefully document the outcomes in achieving the reduction in out-of-home placement days. It is also important to document for the tribe as well as for the county positive outcomes using other indicators, such as improved school attendance as well as capturing outcomes for the family, such as reduction in mental health and substance abuse emergency detentions, and reduction in criminal justice involvement.

6. Medicaid Funding

The ability to maximize Wisconsin Medicaid Revenue is dependent on the number of Medicaid eligible persons, service structure, staffing and supervisory pattern, historical use of resources, and the ability to devote resources to the up front work required to meet the Medicaid certification and billing requirements. Estimating the numbers of consumers, staff and other resources needed to pursue each Medicaid benefit as a funding source is a good first step in deciding where to focus efforts. Potential revenue gains will need to be balanced against the required organizational changes and costs.

The philosophy of most of the Medicaid mental health, substance abuse, and long term support funding sources is generally consistent with the principles and values of the Coordinated Services Team initiative but may use different language – for example, “person-centered planning” in Long Term Support or “recovery-focused” in Comprehensive Community Services (CCS). Combined assessment and treatment plan models have been developed to eliminate duplicative paperwork when possible.

Maximizing Medicaid revenues, however, may require collaboration within the tribal agencies. Some of the services require authorization and service oversight/supervision by therapists and prescriptions by psychiatrists. It may also require staff willing to learn the intricacies of complying with multiple administrative or certification rules, Medicaid Provider Updates/handbooks or contract requirements. Billing staff may need to set up new systems to capture costs and complete the billing process. The type of collaboration required to make use of these Medicaid funds within the tribal agencies mirrors the collaboration expected of child & family team partners.

The information below provides a broad overview of the requirements, covered services, and considerations for use of some key Medicaid funding sources. Much more detail is needed to make decisions about whether to pursue any particular Medicaid program. To view all Medicaid publications, refer to: <http://www.dhs.wisconsin.gov/medicaid/>

The Medicaid program is funded through a shared federal and state fiscal participation. The amount that each state is required to contribute is based on economic factors of each state. In Wisconsin, the state required match is about 40%, with the federal government picking up the rest of the cost, about 60%. The required state share changes some from year to year. In this document the required state match is referred to as “non-federal match”.

A dilemma that Wisconsin’s mental health system faced when new programs were added as Medicaid covered services was the lack of state general purpose revenue to pay for the required non-federal match. In order to avoid increased pressure to the state’s budget, many newer Medicaid funded mental health programs use local county funds to provide the required non-federal match. Some of these programs are: Targeted Case Management (TCM), Comprehensive Community Services (CCS), Community Support Program (CSP) and Crisis Intervention programs. Children’s Long Term Support Waiver programs can also be developed or expanded using the non-state funding as the match. Tribal funding can be used as the non-federal match. For example, Menominee Tribe used tribal funds as match to fund long term care waiver services for tribal elders.

However, there are certain circumstances where the non-federal match for Medicaid services is not required. This opportunity for the state to claim 100% Federal Medical Assistance Percentage (100% FMAP) will be discussed in Chapter 10.

Finally, the discussion below about various Medicaid benefits and programs focuses on the Fee For Services (FFS) system, including the Children’s Long Term Support waivers. These fiscal strategies are not applicable to children who are enrolled in managed care programs and who are served by Health Maintenance Organizations (HMOs).

A. Targeted Case Management

Many county CST programs have accessed Targeted Case Management (TCM) funding as a part of their strategy to sustain the CST; several tribal CST initiatives are also interested in pursuing TCM. Currently one tribe, Oneida, is billing for TCM. Case management services include assisting consumers, and when appropriate, their families, in gaining access to and coordinating a full array of services, including medical, social, educational, vocational, and other services.

Population groups that are eligible for targeted case management are defined in two groups. Group A Target Populations include the following: persons age 65 and over; persons with Alzheimer's or dementia; persons with a developmental disability, chronic mental illness, physical/sensory disability, and persons with alcohol or drug dependency; persons with HIV; and persons with Severe Emotional Disturbance (SED). Group B Target Populations include the following: Families with a child/children at risk of serious physical, mental or emotional dysfunction; children enrolled in Birth to Three Program; children with asthma; individuals infected with tuberculosis; and women age 45-64 who are unaware of how to obtain preventative health care services.

Covered case management services include comprehensive assessment, case plan development, collateral and face-to-face contacts, ongoing monitoring and service coordination and travel time. For Group A Target Populations, one comprehensive assessment and one case plan development is covered each calendar year. For Group B Target Populations, up to two comprehensive assessment and case plans are covered each calendar year. Covered services do not include any direct service provision. Medicaid certified tribes or counties must meet the administrative code requirements (HFS 107, Wis. Admin. Code).

Staff qualifications for performing comprehensive assessments and case plans include meeting the following two requirements: 1. Knowledge of the local service delivery system, the target group's needs, the need for integrated services and the resources available or needed to serve the target population, and 2. A degree in a human service-related field and one year experience, or two years of supervised experience working with the target population, or an equivalent combination of training and experience.

Qualifications for the staff providing ongoing monitoring and service coordination require knowledge of local service delivery system, target population needs, need for integrated services, and resources available or needed.

Medicaid will certify only those counties and tribes that meet the case management requirements in HFS 107, Wis. Admin. Code. The county or tribe must provide the non-federal Medicaid share of case management services. However, as part of the 100% FMAP reimbursement, the state could claim the Targeted Case Management cost provided to eligible persons, thus not needing to require the tribe to provide the non-federal share. (See details in the chapter on 100% FMAP).

Case management includes gaining access to or coordinating non-Medicaid services as well as Medicaid services. Wisconsin Medicaid, however, does not cover service provision as part of the case management benefit. The following are examples of activities not covered as case management: medication set-up, money management, skills training, and taking a client shopping. There are no prior authorization or co-payment requirements for targeted case management.

For more information

Please see state staff contact list in Appendix B and visit the Wisconsin Medicaid Targeted Case Management Handbook on the web at:

<https://www.forwardhealth.wi.gov/kw/pdf/casemanagement.pdf>

B. Comprehensive Community Services

Comprehensive Community Services (CCS) provides an option for counties and tribes to develop a flexible array of community-based psychosocial rehabilitation services. Individualized services are authorized by a mental health professional involved on the recovery team of the CCS consumer who is diagnosed with mental health and/or substance use issues and meets the eligibility requirements for the CCS Program. CCS services are culturally appropriate, and individualized according to the person served, e.g. age specific (adult, older adult, child, adolescent). For children served in CCS, the plan may include services to the family members of children. At the writing of this document (Winter 2011), no tribe operates a CCS.

The intent of CCS services and supports is to provide for a maximum reduction of the effects of the individual's mental health and/or substance abuse disorders, to restore consumers to the best possible level of functioning, to develop capacity or restore consumers to their best possible level of functioning, and to facilitate their recovery. There is no age restriction. Eligible children and adults must meet the eligibility criteria through the adult Mental Health/Substance Abuse Functional Screen or the Children's Functional Screen. The Children's Functional Screen is also used to determine eligibility for Children's Long Term Support waivers.

Services provided are "rehabilitative". These services are individualized to meet each person's needs as identified through a comprehensive assessment. The CCS service array consists of psychosocial rehabilitative services which meet federal rule and definition (42 CFR 440.130(d)). Only counties and tribes may be certified as CCS providers under Wisconsin Administrative Code DHS 36, by the Division of Quality Assurance.

With few exceptions, behavioral health services for individuals enrolled in CCS must be billed through CCS and may not be billed as an outpatient benefit, psychotherapy, diagnostic evaluation, or adult day treatment. However, for children enrolled in CCS, services provided by "Health Check In-Home Mental Health and Substance Abuse Treatment" and "Health Check Child/Adolescent Day Treatment" must be billed on a fee-for-service basis because they are not included in CCS. A medication check by a psychiatrist may be billed either outside CCS or through CCS.

There are no prior authorization or copayment requirements for CCS services. Consumers enrolled in Medicaid managed care may receive CCS services on a fee-for-service basis.

The county or tribe is responsible for financing the non-federal share of CCS services from non-federal public funds. However, similar to the Targeted Case Management services, the state could claim the full cost of CCS services and receive 100% FMAP reimbursement for services provided to eligible persons according to Centers for Medicare and Medicaid Services (CMS) conditions referred to in the section on 100% FMAP.

Each CCS provider initially receives an interim rate approved by the Division of Health Care Access and Accountability. At the end of the calendar year, the Division of Health Care Access and Accountability conducts an annual cost settlement, reconciling the interim payments to the provider's actual costs. When conducting the rate-setting and cost settlement process and program reviews, the state staff may ask counties and tribes to submit a sample of records for review to ensure that providers are only reporting costs that qualify as psychosocial rehabilitative services.

For more information

Please see state staff contact list in Appendix B and visit the Comprehensive Community Services (CCS) portion of the DHS website: http://dhs.wi.gov/mh_bcmh/CCS/index.htm.

C. Health Check “Other Services” for In-Home Mental Health and Substance Abuse Treatment Services

Health Check (Wisconsin’s Early Periodic Screening, Diagnosis and Treatment (EPSDT) program) is a preventive health checkup program for anyone under the age of 21 who is currently eligible for Wisconsin Medicaid or Badger Care Plus Program.

As the name indicates, in-home services can be provided in the person’s home. In-home mental health and substance abuse treatment services are covered when medically necessary and are designed to address an individual child’s treatment needs. These services may be individual or family treatment modalities, or a combination. Treatment needs are determined by an in-depth assessment of the child/adolescent, and an individualized treatment plan with measurable goals and objectives is developed for the in-home services. The child and family are integral to the development of the plan of care and treatment goals.

In order for a child/adolescent who is under age 21 to receive the in-home services a certified mental health (or substance abuse) provider needs to submit a prior authorization request to the Department of Health Services. The child for whom the prior authorization is submitted must have had a Health Check Screen in the past 12 months. All tribal health clinics conduct the Health Check Screens.

For more information

Please see the state staff contact list in Appendix B.

D. Crisis Intervention (also called Emergency Mental Health Crisis Services)

The Medicaid program reimburses a range of services under the certified crisis intervention program. Covered crisis treatment services are provided by certified crisis providers to a recipient in crisis or in a situation that may develop into a crisis if professional supports are not provided. Some of these services include: 24/7 crisis intervention telephone lines, mobile crisis intervention teams and hospital alternative services (including crisis family homes and intensive crisis residential programs), initial assessment and planning, and crisis linkage and follow-up services. Because the requirements for the Medicaid certification are extensive, no tribe currently operates a certified crisis intervention program. However, a concept has been discussed where a tribe could collaborate with a county or multiple counties to be part of a Medicaid certified crisis program.

A tribal CST could benefit from a crisis intervention program’s services in several ways:

- Because each crisis program must provide a 24/7 telephone service, the tribal CST could take advantage of this coverage for its families, rather than having the CST staff provide after hours response. Tapping into this service will require close communication and collaboration between the tribal CST and the crisis intervention program to be successful.
- The provision of linkages and coordination of services to tribal members in crisis situations could be provided under an agreement with the certified crisis intervention program. This way the tribal CST (or other tribal provider) could provide culturally competent service in the tribal community setting. They would also have an opportunity to receive Medicaid reimbursement for the service.
- One of the optional services related to Medicaid crisis intervention is stabilization services to avoid the need to hospitalize the person in crisis. This service can be provided in the person’s home, school or other community setting or by developing a setting, where the person who is experiencing the crisis can go on a short term basis. For example, this setting could be the home of a trained host family. Tribal providers could provide this service as part of the certified crisis intervention program and get reimbursed for it.

Crisis services do not include those services normally provided by providers of mental health and substance abuse services who routinely deal with crises while providing services (e.g. a psychotherapist who helps a recipient through a crisis during their scheduled psychotherapy session).

There is no age restriction. Providers must be certified as a crisis intervention provider under HFS 34, Subchapter III by the Division of Quality Assurance.

Medicaid will certify only those counties and tribes that are certified as Crisis Intervention Providers, HFS 34, Subchapter III by the Division of Quality Assurance. The county or tribe must provide the state/non-federal Medicaid share of crisis intervention services. There are no prior authorization or copayment requirements. A licensed psychiatrist or psychologist, as well as the following licensed treatment professionals when they meet certain additional requirements must authorize services beyond the assessment and initial response plan within fourteen days: licensed clinical social worker, psychiatric nurse, licensed professional counselor or licensed marriage and family therapist. For crisis stabilization one of these professionals must sign off weekly verifying the need for crisis stabilization services. For consumers enrolled in Medicaid managed care, including Family Care, crisis intervention may be provided on a fee-for-service basis.

For more information

Please see state staff contact list in Appendix B.

E. Medicaid Home and Community Based Waivers Serving Children with Long Term Support Needs

States can administer Medicaid Home and Community Based waivers after submitting an application to the Federal Center for Medicaid and Medicare Services. These waivers permit the states to flexibly use Medicaid funds for community supports and services. The waivers give the states the opportunity to develop and implement creative alternatives to placing individuals who are Medicaid eligible in hospitals or nursing homes. The waiver recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to their families and communities, at a cost that is no higher than institutional care.

Wisconsin Department of Health Services (DHS) operates three Children's Long Term Support (CLTS) Waivers serving children with severe emotional disturbance, developmental disabilities and physical disabilities. Counties manage the waivers with an allocation from the Department. In order for the county (or tribe) to be a waiver agency, it needs to meet requirements that are listed in the Department's Home and Community Based Medicaid Waiver Manual. Some counties have indicated that meeting the CLTS waiver requirements is a less complex and time consuming process than meeting the certification requirements of many of the other Medicaid programs. The Department of Health Services has a limited pool of start-up funds to assist CLTS waiver programs to get started.

No tribe is currently a CLTS Waiver agency. However, the waiver program can be a source of funding to serve tribal children with disabilities, including children served by the CST. Because waiver programs operated by tribes could also qualify for 100% FMAP, it would be possible to serve all eligible tribal children with disabilities who are currently on CLTS waiting lists, thus completely eliminating the waitlist for eligible tribal children. CLTS waivers are a significant potential resource to serving tribal children with disabilities, including children with severe emotional disturbance.

The following requirements must be met for the child to qualify for the waiver program:

- The child must meet Medicaid waiver level of care eligibility requirements. A child must need an institutional level of care due to a developmental disability, physical disability, or severe emotional disturbance. This is determined through the Children's Long-Term Support

Functional Screen. Each county waiver agency has staff who have been certified to administer the Functional Screen. (This training is available on line from the Department of Health Services and there is at least one tribe that is planning on getting their own staff certified to perform the functional screen.)

- The child must meet Medicaid financial eligibility requirements;
- The child must meet Medicaid waiver program nonfinancial eligibility requirements, including residency status, etc.;
- The child's preferred living arrangement is appropriate to meet his/her needs and is a community setting (home or foster care);
- The child is determined to have a disability by DHS Bureau of Disability Determination.

The funding is an entitlement until the child reaches a certain age depending on his/her target group and county/tribe of residence. Children with a severe emotional disturbance (SED) can be served by the CLTS waiver until their 22nd birthday. Children with disabilities other than SED who live in counties/tribal areas that are not covered by Family Care can also be served by the CLTS waivers until their 22nd birthday. Children with disabilities other than SED who reside in counties/tribes served by Family Care can transition to Family Care or to an alternative program to managed care called IRIS at age 18. IRIS is a program that allows the client to self-direct his/her long term care services. It was developed as a fee for service alternative to Family Care which is a managed care program.

The CLTS Waiver plan is individualized based on the needs of the child. The CLTS Waiver offers a wide array of very flexible service to meet the needs of the child. Some of these services are daily living skills training, respite care, adaptive aids, and home modifications. Families have found that especially the availability of respite services is often very helpful to them as are home modifications and adaptive aids that can be provided. Targeted Case Management is part of the service array as well. Furthermore, the CLTS waiver services can be combined with other Medicaid services such as CCS. More information is available regarding CLTS Waivers services in the "Home and Community Based Medicaid Waiver Manual".

Within the CLTS Waivers are waiver "slots" (waiver funding) including Children's Crisis Waiver slots. Crisis Waiver slots are obtained from a statewide pool and are available to families experiencing new or increased stress. The Waiver funding is to be used to allow families to keep their child at home. If a child is placed in an out-of-home placement, the crisis slot is no longer available. Slots revert to the state pool when no longer needed; the county does not retain the slot for another child.

For more information

Please see state staff contact list in Appendix B. Also please see the following documents:

- The CLTS Waiver Programs go to: <http://dhs.wisconsin.gov/bdds/clts/index.htm>
- The Home and Community Based Medicaid Waiver Manual go to: <http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>
- The CLTS Waiver supplemental information go to: http://dhs.wisconsin.gov/bdds/waivermanual/app_e.htm

For specific memos related to the CLTS Waivers:

- Policy Guidance on Serving Children in the Children's Long Term Support Waivers and Child Welfare Services: http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DDES/CY_2005/NMemo2005-19.htm
- Children's Waivers Crisis Slots: http://dhs.wisconsin.gov/dsl_info/NumberedMemos/DDES/CY_2004/NMemo2004-22-DDES.htm

7. Community Options Program (COP)

The Community Options Program (COP) helps people who need long term services and supports to stay in their own homes and communities. Its purpose is to provide cost effective alternatives to expensive care in institutions. People of all ages with disabilities as well as older adults are eligible to receive funds and assistance to access services that they are not able to access through other programs. The Community Options Program is operated by counties; however, Oneida Tribe is also a COP agency.

Community Options Programs serve the following target populations: the elderly; and people of all ages who have a developmental disability, physical disability, severe mental illness or substance abuse problems. COP funds are very flexible and can be used for such services as case management, home modifications, respite care, residential services, personal care, housekeeping and home health care. COP funds can also be used to provide the fiscal match for other services such as Medicaid waiver services.

Eligible persons must meet the functional screen requirements and financial eligibility requirements. The functional screen for children is the Children's Long Term Support Functional Screen. (For adults the eligibility tool for COP is the Adult Long Term Care Functional Screen). The eligibility requirement is that the person must be Medicaid eligible or become eligible for Medicaid within 6 months.

In those counties that have implemented Family Care, COP funding continues to be available for children with long term support needs and for persons with severe mental illness and substance abuse problems.

Because COP funds are very flexible, they are very popular and most counties have a waiting list for services. However, tribal CST initiatives should map out how COP funds are used for children and mental health clients by their counties and explore if some COP funds could be targeted to serving children in the CST.

For more information

Please see state staff contact list in Appendix B and COP Guidelines at www.dhs.wisconsin.gov/LTC_COP/COP_Guidelines/index.HTM

8. Family Support Program

The Family Support Program provides individualized services and supports to families with a child who has severe disabilities. This program recognizes that meeting the needs of a child with disabilities may place a hardship on a family's emotional, physical and financial resources. The Program offers information and help in finding services and maximizing community resources, limited funding to purchase needed services and goods that cannot be purchased with other resources, and help in linking families with other families. Counties manage the Family Support Program. Families are eligible if they have a child with a severe disability, under age 21 who is living at home. Because those funds are very flexible, counties usually have a waiting list for the program. However, some families served by tribal CST may benefit from the Family Support Program because of its flexibility to purchase goods and supplies as well as services such as respite.

For more information

Please see state staff contact list in Appendix B and Family Support Manual of Guidelines and procedures at www.dhs.wisconsin.gov/bdds/fsp/index.htm

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9. Increasing Tribal Medicaid Revenues through Full Cost Reimbursement Available to the Tribal Health Care Center

All tribal health care clinics are Federally Qualified Health Centers (FQHCs). The purpose of the FQHC program is to provide covered medical services to Medicaid clients who require ongoing, continuous or repetitive management of their health care. FQHCs receive a payment per encounter, that is a Medicaid billable patient contact, that includes medical services, supplies, and the overall coordination of the services provided to the Medicaid client. The Department of Health Services (DHS) reimburses FQHCs for services provided to Medicaid clients at 100% of the reasonable cost as determined through established cost reporting methodologies or at a Prospective Payment System (PPS) rate, whichever is higher. These supplemental payments take into account the payments previously received through the usual Medical Assistance reimbursement process.

The 100% cost reimbursement is computed based on an encounter rate applied across all professional disciplines. An encounter is a face-to-face contact between a client and a Medicaid certified provider, and it must be documented in the client's record, billed and reimbursed through the Medicaid fee-for-service process. Mental health services provided by Medicaid certified providers are included in the scope of allowable Medicaid services for which the full cost can be reimbursed.

Because tribal behavioral health services are organized under the same "corporate structure" as the Tribal Health Clinic, they include their Medicaid mental health and substance abuse outpatient service costs in the FQHC cost report and thus receive the higher encounter rate for services provided to Medicaid eligible clients and for which Medicaid fee-for-service payment has been received.

The process for receiving the higher encounter rate for mental health and substance abuse outpatient billing is as follows:

1. The tribal program bills the Department of Health Services for Medicaid reimbursement.
2. DHS pays the claim at the established Medicaid rate (but the current reimbursement rate is less than the actual cost).
3. Because the tribal mental health and substance abuse programs are part of the tribal health clinic (FQHC), the health clinic includes the costs of operating these programs in the cost report to DHS.
4. DHS audits the cost reports and determines the encounter rate.
5. DHS pays to the FQHC the difference between the encounter rate established by the audit process less the amount of money already paid to the FQHC through the Medicaid billing or other third party funding sources.

The encounter rate may vary from year to year, depending on the total program costs and the number of patient encounters. In one tribal FQHC, the encounter rates have been between about \$200 and \$400 per encounter. Collaborating with the tribal health clinic for cost reporting and claiming purposes clearly is very advantageous for tribal mental health and substance abuse programs and holds potential for tribal CST providers.

For more information

Please see state staff contact list in Appendix B.

10. Claiming Federal Funding Through the 100% Federal Medical Assistance Percentage (100% FMAP) Process

As mentioned earlier, the provision of healthcare to American Indians and Alaska Natives falls under the federal trust responsibility, rooted in the U.S. Constitution that recognizes the debt owed to Indian tribal governments. With the recognized responsibility to indigenous people has come respect for tribal sovereignty and willingness to work with the tribes on a culturally sound healthcare delivery system.

Each state administers its Medicaid program that is jointly funded by the state and the federal government. The federal government share for funding the Medicaid program ranges from 50% to about 83% with states with lower per capita incomes receiving more federal funds. In Wisconsin the federal match is about 60%, the state share being about 40%.

However, as part of the federal trust responsibility, the federal government will reimburse states 100% of the Medicaid claims when the services are provided to American Indian/Alaska Native enrollees through Indian Health Services and/or tribal facilities serving Native Americans.

In Wisconsin, active work is under way by several tribes and DHS staff to set policies and practices to capture the 100% federal reimbursement.

DHS published a document in July 2010 titled "Eligibility for 100% Federal Medical Assistance Percentage (FMAP)". In short, the persons for whom the 100% FMAP can be claimed must be persons of American Indian descent belonging to the Indian community. To review the entire document, go to: www.dhs.wisconsin.gov/tribalaffairs/10jun/Eligibilityfor100%25FMAP.pdf.

The requirements that govern the 100% FMAP claiming are the following:

1. The service must be a Medicaid covered service,
2. The recipient must be Medicaid eligible,
3. The person must be eligible for Indian Health Services (IHS), and
4. The service must be provided through an IHS facility.

The 100% FMAP billing process requires further work, but some successful efforts are currently under way. For example, the state currently claims 100% FMAP for Anna John Nursing Home operated by the Oneida Tribe, as well as for Medicaid Home and the Community Based Waivers serving adults operated by Menominee and Oneida Tribes.

The Department of Health Services has been very responsive and committed to the 100% FMAP claiming process and is willing to "pass through" the entire amount of Medicaid funding that has been received via this process to the tribes.

Several issues that should assist tribal CST initiatives are still under investigation, such as:

1. How can the 100% FMAP be captured for services that the tribe is providing under a contract?
2. What is the most effective way in the Medicaid billing system to identify the person being eligible for IHS facility services?

Communications from the Department of Health Services as well as further updates of this document will respond to these questions.

For more information

Please see state staff contact list in Appendix B

11. Indian Child Welfare Services

The history of providing child welfare services to American Indian children is riddled with injustice, abuse and trauma for the children and their families. This history includes forced removal of children from their families and communities and separation from their culture, language and traditions. These practices were halted in 1978 when Congress enacted the Indian Child Welfare Act. The goal of the act was to protect the best interests of Indian children and promote the stability and security of Indian tribes and families. This law grants the right of tribes to participate and be key players in child welfare decisions that affect the tribes and their members.

Tribal CSTs are developing collaborative relationships with the tribal child welfare agencies. The main funding source of federal funding for child welfare is the federal Title IV-E program. The IV-E program includes services to children and their families for child protective and community-based juvenile justice services. The Department of Children and Families (DCF) administers the IV-E program. DCF claims all federal IV-E funds through a cost allocation process and is responsible for allocating the funds to tribes and counties. DCF also claims Targeted Case Management Medicaid funds via DHS for case management provided to children who are in placement and are not eligible to have these costs covered by the federal IV-E program. CSTs that have developed excellent working relationships with child welfare services are collaborating and are able to combine child welfare and other funds when serving CST clients who are also in the child welfare system.

For more information

Please see state staff contact list in Appendix B.

12. Conclusion

This document is intended to provide tribal CST staff, tribal mental health clinic staff and tribal fiscal staff a broad list of potential funding sources to sustain the tribal CST initiative. One approach that works for one tribal CST may not fit the other.

Tribal CST staff and other tribal fiscal staff should start planning for fiscal sustainability from the first year when grant funds are received, and tribal CST initiatives are encouraged to seek consultation and assistance from White Pine Consulting Service consultants as well as the staff from the Department of Health Services.

Developing a sound fiscal base for tribal CST initiatives will be key to ensuring that children, adolescents and families struggling with mental health, substance abuse, juvenile justice and many other challenges have the best possible opportunity to heal within their own native communities.

APPENDIX

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Appendix A

A Guide to the Language

Following are some of the phrases and acronyms used in this document.

- **American Indians and Alaska Natives (AIAN or AI/AN).** The official federal term for the indigenous peoples of the Americas, used as a racial classification in the Census and other government statistics. Some of the people in this category prefer to be called *Native Americans*.
- **Federal Trust Responsibility.** The obligation of the U.S. government, recognized in statute and case law, to provide for the health and well-being of American Indians and Alaska Natives. The U.S. accepted the federal trust responsibility in exchange for land under treaties with American Indian Tribes. The federal trust responsibility applies to Alaska Natives under the 1867 treaty for cession of Alaska, which provided that Natives would be treated on the same terms as Indians within the existing United States.
- **Indian Health Service (IHS).** The federal agency within the Department of Health and Human Services that is responsible for providing health services to American Indians and Alaska Natives in accord with the federal trust responsibility. For administrative purposes, IHS divides the U.S. into 12 geographic regions, labeled areas.
- **Indian Health System.** IHS facilities providing direct services to American Indians and Alaska Natives, plus IHS-funded programs run by tribes or tribal organizations and IHS-funded urban Indian health centers. The Indian health system is also referred to as the I/T/U (for Indian Health Service, Tribal, and Urban), or ITU.
- **Medicaid.** The federal program of acute and long-term medical assistance for people with low incomes, established in 1965. States administer Medicaid within constraints set by federal law and regulation and receive partial reimbursement for the costs of the program. In Wisconsin Medicaid services are provided thru several programs: Medicaid Plans for the elderly, blind and disabled; Badger Care Plus for families and Badger Care Plus Core Plan for adults without children.
- **Federal Medical Assistance Percentage (FMAP).** The portion of Medicaid costs the federal government reimburses the state, which varies inversely with state per capita income. FMAP normally ranges from 50 to 83 percent, but states can be reimbursed for 100 percent of the cost of Medicaid services provided by IHS or tribal facilities.
- **Medicare.** The federal program, established in 1965, that provides health coverage for persons who are 65 and older and for some younger people who are disabled. Unlike Medicaid and SCHIP, Medicare is financed and administered by the federal government, with no direct role for the states.
- **Centers for Medicare and Medicaid Services (CMS).** The federal agency within the Department of Health and Human Services that is responsible for SCHIP as well as Medicare and Medicaid. Before 2001, CMS was known as the Health Care Financing Administration (HCFA).

Source:

Northwest Portland Area Indian Health Board
Urban Institute, Washington, D.C.
August 31, 2005

Appendix B

State Staff Contact Directory

Contact	For Information Related To:
<p>Julie Bryda, Division of Long Term Care, Department of Health Services (414) 763-0851 Email: julie.bryda@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Children’s Long Term Support ▪ Family Support Program
<p>Kenya Bright, Division of Mental Health and Substance Abuse Services, Department of Health Services (608) 267-9392 Email: kenya.bright@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Crisis Intervention Program Requirements
<p>Cheryl Lofton, Division of Mental Health and Substance Abuse Services, Department of Health Services (608) 267-1427 Email: cheryl.lofton@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ CCS Program Requirements
<p>Michelle Rawlings, Division of Safety and Permanence, Department of Children and Families (608) 264-9846 Email: michelle.rawlings@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Title IV-E Child Welfare Services
<p>Marlia Moore, Division of Health Care Access and Accountability, Department of Health Services (608) 266-9749 Email: marlia.moore@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ CCS Medicaid Coverage Requirements ▪ Crisis Intervention Medicaid Coverage Requirements ▪ Medicaid Targeted Case Management ▪ HealthCheck “Other Services” In-Home Mental Health and Substance Abuse Treatment Services ▪ Medicaid Coverage for Outpatient Services in the Home and Community for Adults ▪ Federally Qualified Health Centers

Contact	For Information Related To:
<p>Eileen McRae, Division of Health Care Access and Accountability, Department of Health Services (608) 266-4498 Email: eileen.mcrae@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Targeted Case Management
<p>Jim Weber, Tribal Affairs Office, Department of Health Services (608) 267-5068 Email: james.weber@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Tribal Affairs ▪ 100% FMAP
<p>David Rynerson, Tribal Affairs Office, Department of Health Services (608) 261-6728 Email: david.rynerson@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Training for tribes on developing Medicaid Services ▪ Development of a culturally appropriate out-of-home placement facility for tribal youth
<p>Mike Stuve, Division of Health Care Access and Accountability, Department of Health Services (608) 266-0512 Email: michael.stuve@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Audits of Federally Qualified Health Centers
<p>Rita Hallett, Division of Health Care Access and Accountability, Department of Health Services (608) 267-0938 Email: rita.hallett@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Health Check Other Services
<p>Irene Anderson, Division of Long Term Care, Department of Health Services (608) 266-3884 Email: irene.anderson@wisconsin.gov</p>	<ul style="list-style-type: none"> ▪ Community Options Program

Appendix C

Examples of County/Tribe Collaboration

Lac Courtes Oreilles CST and Sawyer County CST:

Both the tribe and the county have received a CST grant from the Department of Health Services. The working relationship between the two CSTs is so good that they have combined their Coordinating Committees for the sake of efficiency and better use of committee members' time. The tribal CST is focusing its target to serving children with a high risk of out of home placement with the goal of reducing Sawyer County's placement costs. If this is successful, the county is willing to consider investing some of the saved funds to sustaining the tribal CST.

Menominee Nation and Shawano County serving tribal elders on Medicaid waiver:

(While this example is about serving the elderly, a similar approach is being developed between DHS and Menominee Nation to serve tribal children who are eligible for Children's Long Term Support waivers.)

Menominee Tribe, Shawano County Social Services Department and the Department of Health Services negotiated a memorandum of understanding to collaborate with the goal of Menominee tribe becoming a designated waiver agency and to claim 100% FMAP for the waiver services provided by the tribe. To achieve this goal, Shawano County staff assisted the tribal staff in conducting the required comprehensive assessments and case plans until the tribal staff was qualified to perform these functions. The county also provided the needed client and fiscal reporting for the tribe's waiver clients using the county's Human Service Reporting System (HSRS) that the tribe did not have. DHS in turn assisted this effort by helping the tribe in meeting the waiver agency requirements and by providing a small amount of Community Options Program funding for Menominee Tribe to hire a consultant to assist in setting up the required program policies and procedures. Menominee Tribe is now an elderly waiver agency and the state claims the full amount of the costs incurred by the tribe in providing the waiver services and receives 100% FMAP, which it passes on to the tribe.