

# Community Based Alternatives for Youth (CBAY)

## Procedure Manual

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES  
STATE OF GEORGIA**

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## 1.0 Introduction

The Community-based Alternatives for Youth (CBAY) Program provides alternatives to treatment provided in a Psychiatric Residential Treatment Facility. Children and youth ages four through 17 and youth or young adults ages 18 through 21 with serious emotional and behavioral disturbances who have a primary diagnosis of mental illness as identified in the DSM-IV and who are placed, or at risk of placement, in a Psychiatric Residential Treatment Facility are served by the program as close to their natural home settings as possible. CBAY has a goal of reducing the length of stay in out-of-home placements and increasing the number of youth receiving community-based services transitioned or diverted from these facilities. In implementing CBAY, Georgia utilizes a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available. The state's entire system relative to youngsters is being transformed to ensure that evidence-based practices, as well as an array of quality services, are available, integrated, and supported throughout Georgia. CBAY supports this transformation.

The program is operated by the Department of Behavioral Health and Developmental Disabilities (DBHDD). The DBHDD is responsible for the following functions: dissemination of information concerning the program to potential enrollees, enrollment of individuals into the program, monitoring waiver enrollment and expenditures, conducting utilization management, recruiting providers and conducting training and technical assistance. The Department uses its External Review Organization to determine PRTF level of care. The State Medicaid agency, the Department of Community Health, is responsible for overseeing the functions performed by the Department and its contracted entities under the waiver.

## 2.0 General Definitions

Commonly used acronyms are listed in Appendix 1.

**Appeal** – A formal request by a Medicaid member for review of the findings of an action when the recipient of services or Legal Custodian disputes the conclusion made by the External Review Organization regarding authorization for admission or continuing stay.

**Approval Determination** – PRTF/CBAY referral has been reviewed by APS and is determined to meet DBHDD PRTF/CBAY admission criteria

**Care Management Entity (CME)** – Entity contracted with DBHDD to provide care management and family support services through the High Fidelity Wraparound model for children and adolescents.

**Care Management Organization (CMO)** - Provides health care services to enrolled members of Medicaid and PeachCare through a partnership between the Department of Community Health and three health care plans – Amerigroup Community Care, Peach State Health Plan, and Wellcare.

**Centers for Medicare and Medicaid Services (CMS)** – The agency of the Federal Department of Health and Human Services responsible for the administration of the Medicaid program.

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**Child & Adolescent Functional Assessment Scale (CAFAS)** - A rating scale which assesses a youth's/young adult's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.

**Clinical Denial** – Denial of authorization for an identified consumer for services requested for which they are deemed ineligible due to lack of demonstrated medical necessity for the service request.

**Community Based Alternatives for Youth (CBAY)** – Five (5) year Waiver demonstration project awarded to DBHDD by Center for Medicaid and Medicare services to provide community alternatives to the Psychiatric Residential Treatment Facility.

**Core Services Provider** – Treatment agencies and the primary entry point into the Georgia behavioral healthcare system managed by the Department of Behavioral Health & Developmental Disabilities.

**Critical Incident** - Any event that involves an immediate threat to the care, health, or safety of a consumer.

**Department of Behavioral Health & Developmental Disabilities (DBHDD)** - Created by the Georgia General Assembly in 2009; formerly the Division of Mental Health, Developmental Disabilities, and Addictive Diseases; responsible for service delivery to consumers across the age spectrum who receive non-CMO Medicaid or State Funded services.

**Department of Community Health (DCH)** - Created in 1999 to serve as the lead agency for health care planning and purchasing issues in the state. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. DCH is also designated as the single state agency for Medicaid. The DCH also pursues and corrects fraud and abuse; develops health policy, approves the development and expansion of health care services and facilities.

**Diagnostic and Statistical Manual of Mental Disorders (DSM)** – Published by the American Psychiatric Association, it provides common language and standard criteria for the classification of mental disorders.

**External Review Organization (ERO)** - An agency under contract with the Department of Behavioral Health and Developmental Disabilities to provide service authorization and utilization review for services.

**Health Insurance Portability and Accountability Act (HIPAA)** - Enacted by the US Congress in 1996, it requires national standards for electronic health care transactions and provides for the security and privacy of health data.

**High Visibility Incident** - Critical incidents which have a system-wide impact, have impact upon, or relevance to, any ongoing litigation, or are likely to be reported in the media.

**Medical Necessity** – In regards to CME, a substantial risk of harm to self or others, or a child who is so unable to care for his/her own physical health and safety as to create a danger to their life; the services can reasonably be expected to improve the recipient's condition or prevent further regression, and all other ambulatory care resources available in the community have

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been identified and if not accessed, determined to not meet the immediate treatment needs of the youth/young adults.

**Money Follows the Person (MFP)** – A rebalancing initiative made possible by an eleven-year grant to States from the Centers for Medicare and Medicaid Services. The grant is designed to help individuals who are institutionalized in in-patient facilities to return to their home and communities.

**Office of State Administrative Hearings (OSAH)** - An office of Georgia state government that seeks to resolve disputes between the public and state agencies in a timely, impartial, courteous, and professional manner.

**Young Adult-** For the purposes of this manual, adults aged 18-21 years old.

**Youth** – For the purposes of this manual, children and adolescents, collectively.

### **3.0 Definition of CBAY Services**

#### **3.1 Behavioral Assistance**

Behavioral Assistance Services provided to support the individual in the community and increase such participant's independence and control over daily life activities and events, as appropriate to the participant's needs and as specified in the plan of care. Services can be delivered in the participant's home or community setting based on the individual's needs as documented in the plan of care. Services provided may include, but are not limited to: assisting the youth/parent/caregiver in organizing their household to be a safe environment; assistance in activities of daily living such as routine household tasks and household management techniques related to the participant acquiring the skills and competencies to become more self-sufficient; protective oversight and behavioral supervision; providing skills training and supervision for youth to develop and encourage social skills, problem-solving, coping, and life skills development and personal care/hygiene/exercise as identified in the youth's approved individual service plan.

#### **3.2 Care Management**

Care Management Services assist participants in identifying and gaining access to needed waiver and other State Plan Services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Care Management Services encourages the use of community resources through referral to appropriate traditional and non-traditional providers, paid, unpaid and natural supports. Care Management Services are a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, and reviewing the delivery and outcome of appropriate services for participants through a wraparound approach. Care Coordinators work in partnership with the participant and their family/caregivers/legal guardian and are responsible for assembling the Child and Family Team, including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities and address participant health and safety issues.

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Care Management Services include the following components as frequently as necessary or at least on an annual basis:

- Comprehensive assessment and periodic reassessment of the participant to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, or other services and include activities such as: taking client history; identifying the needs, strengths, preferences and physical and social environment of the individual, and completing related documentation; gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the participant.
- Development and periodic revision of an individualized service plan (ISP), based on the assessment, that specifies the goals of providing care management and the actions to address the medical, social, educational, and other services needed by the participant, including activities that ensure active participation by the participant and others. The care plan will include a transition goal and plan. If a participant declines services identified in the care plan, it must be documented. The Care Coordinator is responsible for seeking service plan authorization through the operating agency (DBHDD) with oversight by the Medicaid Agency.

Referral and related activities to help the participant obtain needed services, including activities that help link the eligible individual with medical, social, educational providers, and other programs or services that are capable of providing services to address identified needs and achieve goals in the care plan.

- Monitoring and follow-up activities that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the participant. Monitoring includes direct observation, and follow-up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services and the ongoing evaluation of the satisfaction of waiver participants and their families/caregivers/legal guardians with the ISP. These activities may be with the participant, family members, providers, or other entities, and may be conducted as frequently as necessary, and at least on an annual basis, to help determine: whether services are being furnished in accordance with the participant's service plan; whether the services in the care plan are adequate to meet the needs of the participant; whether there are changes in the needs or status of the participant. If changes have occurred,, the individual service plan and service arrangements with providers will be updated to reflect changes.
- Care Management Services may include contacts with individuals that are directly related to the identification of the participant's needs and care, for the purposes of assisting participants' access to services, identifying needs and supports to assist the participant in obtaining services, providing Care Coordinators with useful feedback, and alerting Care Coordinators to changes in the participant's needs.

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- Care Management Services also assist participants and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment and access to this option.

### **3.3 Clinical Consultative Services**

Clinical Consultative Services are provided by professional experts in psychology, social work, counseling, behavior management and/or criminology. These specialized services are provided to youth who have specialized diagnoses/needs which may require an expert to differentiate assessment, treatment, or plans of care. Clinical Consultative Services that are not covered by the State Plan and are necessary to improve the participant's independence and inclusion in their community and to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans. Home or community based consultation activities are provided by professionals in psychology, social work, counseling, behavior management or criminology. The service includes assessment, development of a home treatment/support plan, training, technical assistance and support to carry out the plan, monitoring of the participant and other providers in the implementation of the plan and compensation for participation in the Child and Family Team meetings. Crisis counseling and stabilization and family or participant counseling may be provided. This service may be delivered in the participant's home, other community home such as foster care, in the school, or in other community settings as described in the Individual Services Plan to improve consistency across service systems.

### **3.4 Community Transition Services**

Community Transition Services are: non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Community Transition Services are: non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- a. security deposits that are required to obtain a lease on an apartment or home;
- b. essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- c. set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- d. services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;

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- e. moving expenses; and
  - f. necessary home accessibility adaptations.

Additionally, non-recurring expenses to facilitate independent transportation opportunities, such as driver's license, driver's training or vehicle registration in instances where a vehicle has been donated are allowable. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources such as DFCS Independent Living Program, Rehabilitation Act. Community Transition Services do not include monthly rental or mortgage expense; food; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may not be used to pay for furnishing or setting up living arrangements that are owned or leased by a waiver provider.

### **3.5 Customized Goods and Services**

Customized Goods and Services are individualized supports that youth who have severe emotional disturbances or mental illness may need to fully benefit from mental health services. It includes services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the individual service plan and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participants safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. The specific Customized Goods and Services must be clearly linked to a participant behavior/skill/resource need that has been identified and documented in the approved ISP prior to purchase or delivery of services. Goods and services purchased under this coverage may not circumvent other restrictions of waived services, including the prohibition against claiming for the costs of room and board. The Care Coordinator may provide support and assistance to the participant/representative in budgeting and directing goods or services to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipt that provides clear evidence of purchase must be on file in the participant's records to support all goods and services purchased. Customized Goods and Services could include tutoring; parenting skills; homemaker services, structured mainstream recreation, therapeutic or day support activities; mentor or behavioral aid; a utility deposit to help stabilize a child's behavioral health crisis; environmental modification to the participant's residence to enhance safety and ability to continue the living arrangement, among other customized goods and services to provide flexible community services and to maintain stability in their residence.

### **3.6 Expressive Clinical Services**

Expressive Clinical Services are not covered by the State Plan and are necessary to improve the participant's independence and inclusion in their community and

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to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans.

### **3.7 Family Peer Support Services**

Family Peer Support Services are participant centered services with a rehabilitation, recovery and maintenance focus designed to promote skills for coping with and managing mental illness symptoms related to the participant's treatment plan while facilitating the utilization of natural resources and the enhancement of community living skills and participation. These services promote participant socialization, recovery, self-advocacy, development of natural supports, and access to services through information and assistance. Training may include, but is not limited to: individual and group training on diagnosis; medication management; treatment regimens including evidence based practices; behavior planning, intervention development and modeling; skills training; systems mediation and self-advocacy; financial management; socialization; individualized education planning; and systems navigation. Services are directed toward achievement of the specific participant goals defined in the approved Individual Service Plan (ISP), and must be approved by the Care Coordinator in advance. Training services are available for individuals who provide support, training, companionship or supervision to participants served in the waiver and these services must be directly related to their role in supporting the participant in the areas specified in the CFT Action Plan. For purposes of this service, individual is defined as any person, who lives with or provides care to a waiver participant, and may include a parent, caregiver, foster parent, legal guardian, relative, grandparents, family member in the home, family home respite provider, neighbor, friend, companion or natural support who provides uncompensated behavioral care, training, guidance, companionship, or support to a child/youth served in the waiver. Peer or family peer supports may be provided to assist the unpaid caregiver in meeting the needs of the participant. This service may not be provided in order to train paid caregivers or school personnel. FFP is also available as compensation to the providers of this service for participation on the Child and Family Team meetings.

### **3.8 Financial Support Services**

Financial Support Services are services or functions that assist the family or participant to:

- a) Manage and direct the disbursement of funds contained in the participant-directed budget;
- b) Facilitate the employment of staff by the family or participant by performing employer responsibilities as the participants agent, and
- c) Performing fiscal accounting and making expenditure reports to the participant or family, Care Coordinator and state authorities.

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Financial Support Services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended. The Financial Support Services (FSS) provider receives and disburses funds for the payment of participant-directed services under an agreement with the Department of Community Health, the State Medicaid agency. The FSS provider files claims through the Medicaid Management Information System for participant directed goods and services. Additionally, the FSS provider deducts all required federal, state and local taxes. The FSS provider also calculates and pays as appropriate, applicable unemployment insurance taxes and worker compensation on earned income. The FSS provider is responsible for maintaining separate accounts on each member's participant-directed service funds and producing expenditure reports as required by the Department of Community Health and the Department of Human Resources. When the participant is the employer of record, the FSS provider is the Internal Revenue Service approved Fiscal Employer Agent (FEA). The FSS provider conducts criminal background checks and age verification on service support workers. The FSS provider executes and holds Medicaid provider agreements through being deemed by the state to function as an Organized Health Care Delivery System or as authorized under a written agreement with the Department of Community Health, the State Medicaid agency. The FSS provider must not be enrolled to provide any other Medicaid services in Georgia. Financial Support Services must be authorized prior to service delivery at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

### **3.9 Respite**

Respite services provide safe and supportive environments on a short-term basis for participants unable to care for themselves because of the absence or need for relief of those persons who normally provide care for the participant. Additionally, Respite Services may be provided for support or relief from the caretaker of the youth participating in the Waiver. This service reduces the risk of out-of-home placements at a higher level of care. Federal financial participation will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite is available twenty-four (24) hours/seven (7) days a week. Respite Services may be in quarter-hour increments or overnight, and may be provided in-home or out-of-home in the following locations: (1) Participant's home or private place of residence, (2) The private residence of a respite care provider, (3) Foster home ÿ Group home. The need and plan for Respite Services must be documented in the approved ISP prior to service delivery at least annually.

### **3.10 Supported Employment**

Supported Employment consists of ongoing supports that enable participants with severe emotional disturbances or mental illness for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their serious mental illness, need supports to perform in a regular work setting. Supported Employment services consist of ongoing supports that enable participants

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with severe emotional disturbances or mental illness for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their serious mental illness, need supports to perform in a regular work setting. It provides one-to-one intensive on-going supports in preparing for, securing, and maintaining competitive employment in a regular work setting. Supported Employment may include assisting the participant to locate a job or develop a job. Supported employment is provided in a variety of settings, particularly work sites where persons without disabilities are employed. The service includes activities needed to sustain paid work by participants and includes supervision and training. When these services are provided, payment is made only for the special adaptations, supervision, and training required by the participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting. These services are provided to enable eligible individuals to choose, obtain or maintain individualized, competitive employment, in an integrated work environment, consistent with their interests, preferences and skills. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program. Supported Employment services include transportation of participants to community work sites. Transportation provided through Supported Employment is included in the cost of doing business and incorporated in the administrative overhead cost. Separate payment for transportation only occurs when the distinct Transportation Services are authorized. Supported Employment services must be authorized prior to service delivery at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. Supported employment services may be provided individually or in group settings, and to obtain a job for a participant.

### **3.11 Waiver Transportation**

Waiver Transportation Services enable waiver participants to gain access to waiver and other community services, activities, resources and organizations typically utilized by the general population, as specified in the Individual Service Plan. Waiver Transportation Services enable waiver participants to gain access to waiver and other community services, activities, resources and organizations typically utilized by the general population, as specified in the Individual Service Plan. These services do not include

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transit provided through Medicaid non-emergency transportation. Waiver Transportation services are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. Whenever possible, family, neighbors, friends or community agencies, which can provide this service without charge, are to be utilized. Transportation services are not intended to replace available formal or informal transit options for participants. The need for Waiver Transportation services and the unavailability of other resources for transportation must be documented in the ISP. Transportation services are not available to transport an individual to school (through 12th grade). Transportation to and from school is the responsibility of the public school system or the waiver participant's family. Waiver Transportation services must not be available under the Medicaid State Plan, IDEA or the Rehabilitation Act. Waiver Transportation services must be authorized prior to service delivery, and must be authorized in the ISP development and with any ISP revisions. Waiver Transportation Services do not exceed \$1,500 annual maximum.

### **3.12 Youth Peer Support Services**

Youth Peer Support Services are designed to promote socialization, recovery, wellness, self-advocacy, development of natural supports, and development/maintenance of community living skills. These services are only for participants who opt for participant-direction. The participant determines the amount of Youth Peer Support Services, if any, and the specific services that the Youth Peer Support will provide. These services must be included in their approved Individual Service Plan. Youth Peer Support Services help participants and their families define and/or direct their own services and supports and to meet their participant-direction responsibilities. It facilitates the participant (or the participants family or representative, as appropriate) in arranging for, problem-solving and decision making in developing supportive community relationships and other resources that promote implementation of the Individual Service Plan. This service is available to assist participants in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting respite care workers and providing information on effective communication and problem-solving. The service/function also includes providing information to ensure that participants understand the opportunities and responsibilities involved in directing their services. Youth Peer Support Services do not duplicate Care Management Services or Financial Management Services. Youth Peer Support Services do not include procurement, fiscal and accounting functions included in Financial Management Services. Community Guides cannot provide other direct waiver services, including Care Management, to any waiver participant. Youth Peer Support agencies cannot provide Care Management Services. The specific Youth Peer Support Services to be received by a waiver participant are specified in the Individual Service Plan. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a Youth Peer Support for that participant. Youth Peer Support Services must be

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authorized prior to service delivery by the Care Coordinator at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

#### 4.0 Service Requirements

1. Ensuring all youth served meet the Psychiatric Residential Treatment Facility (PRTF) Level of Care
2. Enrolling all youth into the program
3. Ensuring that all families are given their choice of service and service provider(s)
4. Ensuring that everything possible is done for the youth to maintain them in the community before institutional care is presented as an option.
5. Ensuring that the Care management Entity (CME) receives notification of the referral within 2 business days of receipt by the Operating Agency, DBHDD
6. Ensuring that the youth is receiving the clinical services in the community necessary to maintain the youth safely in the community.
7. Ensuring that an individualized crisis and safety plan is developed for each youth
8. Reviewing all additional services and supports for each youth, in accordance to policy guidelines, at least quarterly.
9. Reviewing all service plans within 5 business days of receipt of a completed packet.
10. Tracking of services and dollars spent.

Services may continue to be provided to individuals who reach the age of 21 while in the CBAY program as long as the individual was receiving the services immediately before reaching age 21 and all other continued stay criteria are met. Individuals must be discharged or transitioned to other appropriate adult services prior to age 22.

#### 5.0 Description of Youth/Young Adults Served

##### 5.1 Target Population

Children, Adolescents, and Young Adults ages 21 or younger who are Uninsured or have Medicaid eligibility and:

- Require an intensive program in an out-of-home setting due to behavioral, emotional, and functional problems which cannot be addressed safely and adequately in the home;
- Have a Mental Health Diagnosis; Co-Occurring Substance-Related Disorder and Mental Health Diagnosis; Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities

Youth/Young Adults with the following conditions are **excluded** from admission because the severity of cognitive impairment precludes provision of services in this level of care:

- Severe and Profound Mental Retardation

The following diagnoses are not considered to be a sole diagnosis for this service:

- Personality Disorders
- Rule-Out (R/O) diagnoses

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Youth/Young Adults with the following conditions are **excluded** from admission unless there is clearly documented evidence that a psychiatric diagnosis is the foremost consideration for psychiatric intervention:

- Organic Mental Disorder
- Traumatic Brain Injury

Youth/Young Adults with the following conditions are **excluded** from admission unless there is clearly documented evidence that an additional psychiatric diagnosis is the foremost consideration for psychiatric intervention:

- Conduct Disorder

Youth/Young Adults with the following conditions are **excluded** from admission unless there is clearly documented evidence that a psychiatric diagnosis is the foremost consideration for this psychiatric intervention:

- Mild Mental Retardation
- Moderate Mental Retardation
- Autistic Disorder

Behavioral health issues must not include those behaviors that are indicative of the normal developmental process or delinquent behavior not associated with the identified behavioral health diagnosis.

## 5.2 Admission Criteria

All Youth/Young adult must meet the target population criteria as noted above and also meet one or more of the following:

CASII or LOCUS at or above a Level 6 or a CAFAS score of 140 or above and a home scale of 30 and one of the following

1. Youth/Young adult has shown serious risk of harm in the past thirty (30) days, as evidenced by the following:

A. Current suicidal or homicidal ideation with clear, expressed intentions and/or current suicidal or homicidal ideation with past history of carrying out such behavior; and **at least one of the following**:

1. Indication or report of significant and repeated impulsivity and/or physical aggression, with poor judgment and insight, and that is significantly endangering to self or others.
2. Recent pattern of excessive substance use (co-occurring with a mental health diagnoses as indicated in target population definition above) resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
3. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety.

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2. The clinical documentation supports the need for the safety and structure of treatment provided in a high level of care and the youth/young adult's behavioral health issues are unmanageable as evidenced by **both**:

- A. There is a documented history of multiple admissions to crisis stabilization units or psychiatric hospitals (in the past 6 months) and youth/young adult has not progressed sufficiently or has regressed; **and two of the following**:
1. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs, **and**
  2. Past response to treatment has been minimal, even when treated at high levels of care for extended periods of time, **or**
  3. Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure.

**AND**

- B. Youth/Young adult and/or family has history of attempted, but unsuccessful follow through with elements of a Resiliency/Recovery Plan which had resulted in the exhibition of specific mental, behavioral or emotional behaviors that place the recipient at imminent risk for disruption of current living arrangement including:
1. Lack of follow through taking prescribed medications,
  2. Following a crisis plan, **or**
  3. Maintaining family integration.

*Youth enrolled in the CBAY – MFP Program will also have to meet the criteria above, as well as have been in the PRTF for 90+ days, had one day paid for by Medicaid and be transitioning to a qualified house (a familial home or a group home with fewer than 4 youth that are unrelated). Youth enrolled in CBAY – BIP will have to meet the criteria above as well as one of the following: diversion from PRTF, been in the PRTF less than 90 days or transitioning off of the CBAY-MFP program and continue to meet the PRTF level of care.*

## **6.0 Referral Processes**

CBAY admissions are not considered emergent and must be authorized by the External Review Organization.

### **6.1 Referral Process into the CBAY Program through Money Follows the Person (MFP)**

The ERO is responsible for determining if the youth/young adult meets clinical criteria. The referring PRTF faxes to the ERO:

- a) The PRTF Referral Packet Cover Sheet and Referral Review Form
- b) A current Psychiatric evaluation (to include current diagnosis, current medications, and current symptoms) that has been completed within sixty (60) days of the application submission date.

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- c) A Psychological evaluation completed within two (2) years that contains a valid assessment of cognitive functioning. [Under rare circumstances (e.g. youth/young adult is too unstable to be evaluated, there is no immediate access for a psychological evaluation, etc.) the ERO may determine a psychological evaluation is not necessary when the psychiatric assessment provides a thorough and valid psychosocial history, as well as cognitive functioning information; and/or a psychological evaluation that is over two (2) years old contains information that has not changed significantly – in these cases, the ERO will determine if a psychological evaluation is needed and will document in the youth/young adult’s record why the omission of a current psychological evaluation is acceptable.]
  - d) Psychosocial summary, including a complete placement history, completed within sixty (60) days of the application submission date.
  - e) If applicable, a psychosexual evaluation completed within the past two (2) years.
  - f) MFP-CBAY Enrollment Packet
    - i. If the youth is under 18 years of age, and not emancipated, the legal guardian/custodian must sign the Treatment Choice Form
    - ii. If the youth/young adult is emancipated or 18 years or older, the youth/young adult must sign the form, unless iii. (below) applies. If emancipated a copy of the court order must be submitted.
    - iii. If the young adult is 18 years or older and has a legal guardian, then the legal guardian signs the Treatment Choice Form and a copy of the court order must be submitted.
  - g) Court order indicating DJJ Commitment, if applicable.
  - h) Screen shot of Medicaid Portal for the youth/young adult showing type (if any) of Medicaid coverage.

Once all documents are received by the ERO Care Management Department via fax, an application packet is considered complete and eligible for clinical review. If the youth/young adult is enrolled in CMO Medicaid or PeachCare for Kids, the PRTF Institutional Medicaid packet must be submitted to change the CMO Medicaid or PeachCare for Kids to non-CMO Medicaid, if approval is granted. If approved for CBAY/MFP the referring PRTF, Parent/legal custodian/young adult with no guardian, and CME staff determine the course of CBAY/MFP services and treatment. If denied CBAY/MFP, the Medicaid member has appeal rights.

## **6.2 Referral Process into the CBAY Program through Balancing Incentive Program (BIP)**

The ERO is responsible for determining if the youth/young adult meets clinical criteria. The referring PRTF faxes to the ERO:

- a) The PRTF Referral Packet Cover Sheet and Referral Review Form
- b) A current Psychiatric evaluation (to include current diagnosis, current medications, and current symptoms) that has been completed within sixty (60) days of the application submission date.
- c) A Psychological evaluation completed within two (2) years that contains a valid assessment of cognitive functioning. [Under rare circumstances (e.g. youth/young adult is too unstable to be evaluated, there is no immediate

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access for a psychological evaluation, etc.) the ERO may determine a psychological evaluation is not necessary when the psychiatric assessment provides a thorough and valid psychosocial history, as well as cognitive functioning information; and/or a psychological evaluation that is over two (2) years old contains information that has not changed significantly – in these cases, the ERO will determine if a psychological evaluation is needed and will document in the youth/young adult's record why the omission of a current psychological evaluation is acceptable.]

- d) Psychosocial summary, including a complete placement history, completed within sixty (60) days of the application submission date.
- e) If applicable, a psychosexual evaluation completed within the past two (2) years.
- f) CBAY Enrollment Packet
  - i. If the youth is under 18 years of age, and not emancipated, the legal guardian/custodian must sign the Treatment Choice Form
  - ii. If the youth/young adult is emancipated or 18 years or older, the youth/young adult must sign the form, unless iii. (below) applies. If emancipated a copy of the court order must be submitted.
  - iii. If the young adult is 18 years or older and has a legal guardian, then the legal guardian signs the Treatment Choice Form and a copy of the court order must be submitted.
- g) Court order indicating DJJ Commitment, if applicable.
- h) Screen shot of Medicaid Portal for the youth/young adult showing type (if any) of Medicaid coverage.

Once all documents are received by the ERO Care Management Department via fax, an application packet is considered complete and eligible for clinical review. If the youth/young adult is enrolled in CMO Medicaid or PeachCare for Kids, the PRTF Institutional Medicaid packet must be submitted to change the CMO Medicaid or PeachCare for Kids to non-CMO Medicaid, if approval is granted. If approved for CBAY/MFP the referring PRTF, Parent/legal custodian/young adult with no guardian, and CME staff determine the course of CBAY/MFP services and treatment. If denied CBAY/MFP, the Medicaid member has appeal rights.

## **7.0 Enrollment Process**

1. PRTF submits Lateral Transfer application to APS
2. Within 5 days APS determines if referral meets Level of Care(LOC)
3. If referral meets LOC :
  - a. APS sends referral, including Enrollment Packet and Clinical Documentation to [cbayreferrals@dbhdd.ga.gov](mailto:cbayreferrals@dbhdd.ga.gov)
  - b. The Enrollment Packets includes:
    - Treatment Choice Form
    - Unified Release of Information
    - Overview & Consent

- 
- Referral Form
  - Authorization for Use or Disclosure
  - Informed Consent for Participation
  - MDS
  - Referral Clinical Documentation including (approval letter and clinical support documentation)
  - APS Continuing Stay Data
4. Within 1-2 business days CBAY Quality and Data Coordinator check all portals i.e., CBAY Referrals.
- Enroll youth in Synthesis
  - Enter youth in PPL(Public Partnership) TPA
  - Inform appropriate CME – Viewpoint Health or Lookout Mountain of referral
  - Waiver Coordinators & C&A Specialist will:
    - a. Print all documents and scan each individually to the I drive
    - b. Create Folder
    - c. Check Medical Eligibility
    - d. Check CID Number
    - e. Create budget in TPA
    - f. Enter youth in Synthesis and Access Data base
    - g. Send referral email to CMEs & Regions

#### **A. Saving the Referral**

1. Open the referral mailbox.
2. Look for any emails that should read: Referral Summary PRTF to CBAY/MFP (lateral transfer).zip
3. Highlight the subject line with lime green from the categories box after clicking on the subject line
4. Print the cover letter.
5. Save the zip file to the I drive by clicking on it without opening it with a single left click.
6. Then a pop up box will open with several options, chose save link as . . .
7. It is saved to the I Drive By going to computer, I drive, Programs and Policies, CBAY, Referrals and Save.
8. In referrals, save the file (unzipped) with LastName\_FirstName followed by current date, such as 5-5-2013 (\*See alternative saving mode in 2c below).
9. After saving, open up the email (password is 2013@Cbay) to print the contents of the referral.
10. Print the sets of information that you will see when you open up the zip.
11. Some sets of information require printing in the Photo Printing Process. In which case just follow the prompts.

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**B. CBAY Folder Creation and Processes - Check these steps off on the CBAY Internal Checklist as you go.**

1. Check the file to see if the following articles are present. If not, then request them from the referring provider as the date of admission to CBAY cannot start until the file is complete. This includes having complete signatures for the following paperwork based on youth's funding source:
  - a. **CBAY Youth:**
    - i. Treatment Choice
    - ii. Unified Release of Information
    - iii. CBAY Overview and Consent
    - iv. MDS
  - b. **CBAY MFP Youth:**
    - i. CBAY MFP Treatment Choice
    - ii. CBAY MFP Unified ROI
    - iii. CBAY MFP Overview & Consent
    - iv. MDS
    - v. CBAY MFP Referral Form
    - vi. MFP Authorization for Use or Disclosure (2)
    - vii. MFP Informed Consent for Participation
  - c. **CBAY BIP Youth:**
    - i. Treatment Choice
    - ii. Unified Release of Information
    - iii. CBAY Overview and Consent
    - iv. MDS
2. After checking that all forms are present, scan each document individually in an email to yourself. Then:
  - a. Open each email and save by the name of the document to a new file in MFP Uploads. This is a working file in I drive; Prog\_Pol; CBAY; Referrals; and MFP Uploads. Name the file LastName\_FirstName
  - b. When all of the documents are in the file, zip it by:
    - i. Right click the file
    - ii. Go to send to
    - iii. Choose zip
    - iv. Now the file is zipped
  - c. Once zipped, the file can be stored under the child's original file in referrals under LastName\_FirstName. (\*Alternative saving mode).
3. For MFP CBAY youth:
  - a. When the entire file is ready, upload it to DCH. Open the File Zilla by clicking on the Fil Zilla icon on your desktop. The user name is dbhdd-cbay; the password is Winter 2013.

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### C. Medicaid Eligibility

1. Go to <https://portal.dch.ga.gov/Citrix/MetaFrame/auth/login.aspx>
2. Sign in
3. Choose the DCH Intranet logo
4. A gray box that warns users not to open unless they are authorized opens
5. Click OK
6. Another box may opens that has a red circle with an x on it
7. Close that box
8. The DCH Intranet pops up
9. Go to the address section even if it still says connecting
10. Enter <https://home.gammis.com/home/>
11. The Georgia Department of Health site opens
12. Sign in with your password
13. Choose Interchange
14. The Georgia MMIS box will open up
15. To the upper left on the gold bar choose member
16. Enter the last name, first name and DOB
17. Hit enter
18. The Medicaid form will open up
19. Scroll down to the navy bar that reads Member Maintenance
20. To the right is a list of areas to add or modify
21. If you do not see benefit plan, click on another area in that list and then scroll up just a little bit. Benefit Plan is at the top of the middle column.
22. When you see Benefit Plan click on that
23. Scroll down to a section that reads Benefit Plan
24. Under the column that reads End Date look for a date that ends in 12/31/2299
25. Look for one of these categories which will be regular Medicaid insurance:
  - i. SSI
  - ii. Adoption Assist
  - iii. Child Welfare Foster Care
  - iv. State Funded Adoption Assist
26. If you see TXIX Title XIX Medicaid, highlight and click on that
27. The type of Medicaid will be seen under Aid Category Data
- Alternatively, CMO Insurance will be one of these categories:
  - i. RSM,
  - ii. LIM
  - iii. Peachcare
28. If so, then go to Member Maintenance Managed Care and highlight PMP assignments
29. This will show the name of their present insurance which will show an end date of 12/31/2299

- 
30. Children enrolled in the CMOs will be enrolled in the same manner, but please note the particular CMO on the purple enrollment checklist. CMEs are required to partner with the CMO to ensure that the child has their medical care to the same extent as Medicaid enrolled children.

#### **D. CID Number Check**

1. Go to <https://careconnection-prtf.apshealthcare.com/Login/logon.aspx>
2. Sign in
3. Enter child's last name, Medicaid ID and social security number if available
4. Hit search
5. Several continuing stays and perhaps a discharge will populate.
6. Click on the latest one and a great deal of information will be available including the CID #.
7. Log out.

(If there is no CID#, contact Theresa Smith. She is available at [tssmith@dhr.state.ga.us](mailto:tssmith@dhr.state.ga.us) and 404-657-0639 or 770-210-1574. She is very helpful.)

1. Budget created in the TPA
8. Open up the TPA and go to the consumer search tab
9. Click on enroll a new consumer
10. Enter the information in these fields  
(if the CID # is missing, start to enter 0s.
  - i. A temporary number can be created by entering 0s and then watch for numbers to automatically populate in a drop down box. Add new numbers to the 0s to create a new number.
  - ii. Remember to go back later and add the CID# when it is available.
11. Click on save at the bottom of the form
12. Then click on consumer search again
13. The newly entered name will come up
14. Click on referrals
15. Click on new budget
16. Enter the start date and the end date should populate automatically. The start date is generally the APS date unless information is missing in the APS packet, or if the child has CMO coverage (see CMO above).

#### **E. MDS entered**

1. Click on consumer profile
2. Click on MDS at the bottom of that page
3. Click on the time period
4. Fill in the blanks from the initial MDS in the referral package.
5. If there are blanks, put 888 for I do not know, or 999 for NA.
  1. Identify the CME

6. This is on the Treatment Choice form

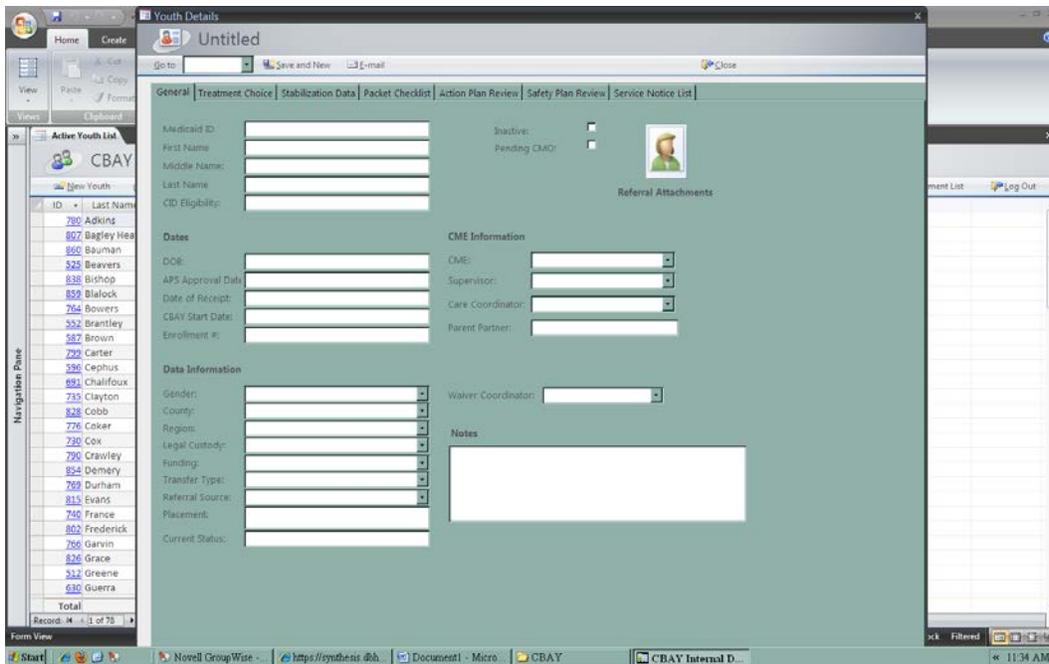
### F. Enter info into Access database

1. Start Button
2. My computer
3. J Drive
4. CBAY
5. Old CBAY Internal Database Production
6. Username
7. Password
8. Log In

The screenshot displays the 'CBAY Active Youth List' window. The table contains the following data:

ID	Last Name	First Name	Medicaid ID	DOB	CBAY Start Date	CME	Enrollment #	Waiver Coord	Discharge
654	Johnson	Antonio J	111091392015	1/4/2002	3/29/2012	MAAC	2	Theresa	<input type="checkbox"/>
643	Johnson	Chase	11176780743	3/5/1998	7/28/2011	MAAC	1	Toni	<input type="checkbox"/>
819	Juarez-Navarrete	Maribel	111584667502	1/8/1996	8/29/2012	MAAC	1	Theresa	<input type="checkbox"/>
844	Keye	Keji	111088234947	4/8/1998	9/24/2012	MAAC	1	Toni	<input type="checkbox"/>
855	King	Roshanda	111829294796	4/4/1996	5/29/2013	GRN	1	Toni	<input type="checkbox"/>
856	Klugh	Antwon	111219585136	1/7/2000	5/24/2013	GRN	1	Adell	<input type="checkbox"/>
411	Krieger	Julia	222111106200	4/23/1995	7/12/2011	MAAC	1	Toni	<input type="checkbox"/>
421	Larcom	Brittany	111839196806	6/28/1996	7/20/2011	MAAC	1	Toni	<input type="checkbox"/>
700	Lawson	Dareyon	111716609642	2/7/1996	5/2/2012	Chris Kids	1	Theresa	<input type="checkbox"/>
858	Lewis	Damion	111051467984	4/25/2002	6/4/2013	Lookout Mountain	2	Toni	<input type="checkbox"/>
729	Locke	Ashlyn	111786644762	9/22/2000	7/25/2012	Chris Kids	1	Toni	<input type="checkbox"/>
803	Maddox	Katelin	111789718700	6/4/1996	8/28/2012	MAAC	2	Adell	<input type="checkbox"/>
839	Martin	Alexandra	222112234272	3/7/1996	9/21/2012	MAAC	1	Toni	<input type="checkbox"/>
804	Martin	Justin	111656445624	2/16/2002	8/28/2012	Chris Kids	2	Adell	<input type="checkbox"/>
736	Maynor	Jacob	111312187278	9/9/2000	6/5/2012	MAAC	1	Adell	<input type="checkbox"/>
772	Mayo	Nicholas	222111166680	12/10/1998	8/1/2012	GRN	1	Adell	<input type="checkbox"/>
808	McCrary	Charles	111076576043	2/10/2003	8/21/2012	MAAC	1	Adell	<input type="checkbox"/>
423	Meeke	Austin	111926654845	3/8/2001	7/22/2011	GRN	2	Toni	<input type="checkbox"/>
633	Michael	Samuel	111527978455	7/16/2001	2/28/2012	Chris Kids	1	Theresa	<input type="checkbox"/>
783	Mitchell	Kaleb	111867991706	6/13/2001	8/2/2012	MAAC	1	Theresa	<input type="checkbox"/>
848	Mitchell	Tyrik	111323730219	11/21/1999	9/28/2012	MAAC	2	Toni	<input type="checkbox"/>
752	Mitchell	Zanaulica	111389709532	2/27/2003	6/18/2012	MAAC	1	Adell	<input type="checkbox"/>
857	Murray	Deanna	111352948311	5/9/1997	5/24/2013	GRN	1	Theresa	<input type="checkbox"/>
743	Muscat	Ashley	111261880971	4/1/1996	6/7/2012	MAAC	2	Adell	<input type="checkbox"/>
717	Pastor	MeKeonna	111453407377	2/12/1998	5/17/2012	MAAC	1	Adell	<input type="checkbox"/>
861	Peavy	Tommy	111816947739	6/3/1998	6/12/2013	GRN	1	Toni	<input type="checkbox"/>
Total									

### New Youth Tab



### Enter General Info Tab Information

- Medicaid Info
- Medicaid Id Number
- First Name
- Last Name
- CID Eligibility

### Data Information

- Gender
- County
- Region
- Legal custody
- Funding

### Referral Source

- Placement

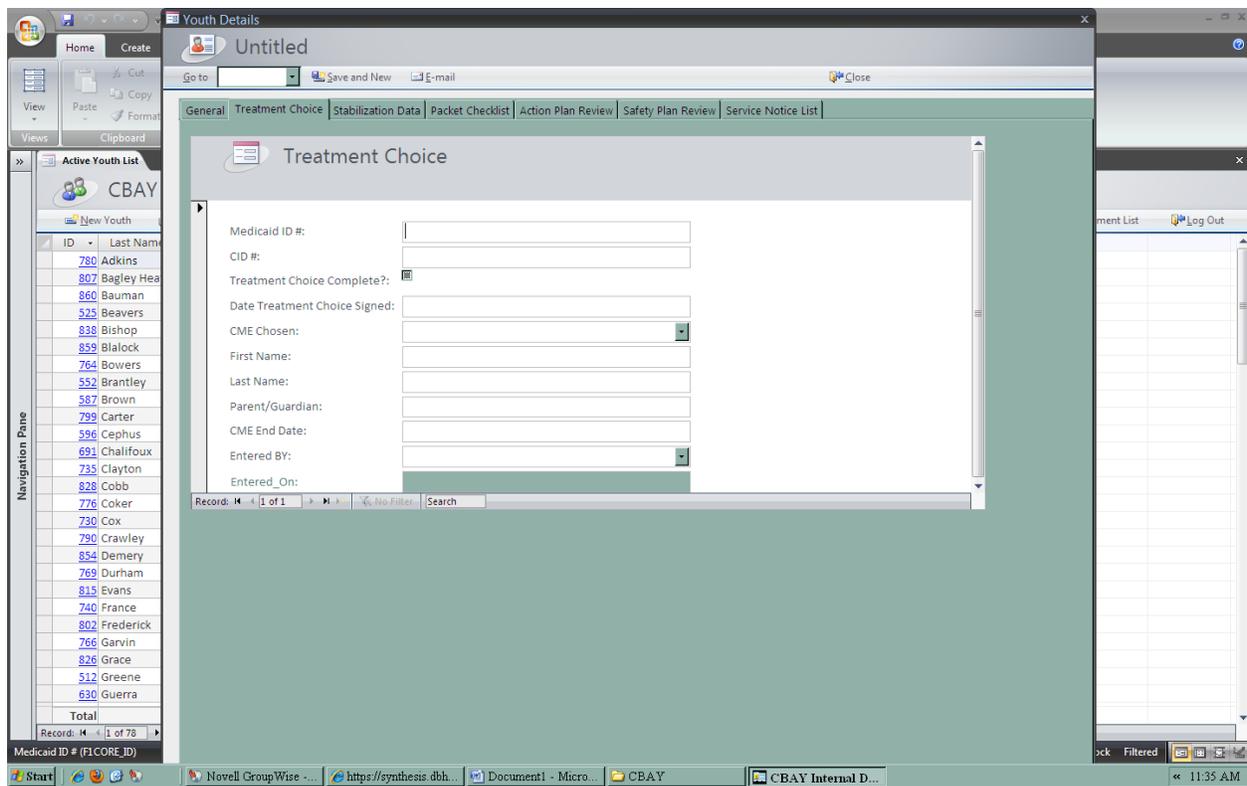
Save as New

### Dates

- DOB
- APS Approval Date
- Date of Receipt
- CBAY Start Date
- Enrollment

### CME Info

- Supervisor
- CC
- FSP
- Waiver Coordinator



### Treatment Choice Tab

- Complete Information
- Save as New
  1. Enter info into Synthesis
  2. Create a participant folder
- 9. Use the blue six section folders
- 10. Punch all of the referral information with the 2 hole paper punch
- 11. Place in this order:
  - i. APS cover sheet, Referral Summary, Document Checklist, Unified Release of Information, MFP Overview and Consent, MFP Referral form, MFP Informed Consent, MFP Health Information Release, Referral Review Form, Treatment Choice
  - ii. Referral information
  - iii. MDS
  - iv. Communications
  - v. (Blank at this time)
  - vi. DRF forms

### G. Emailing information to the CME, et al.

1. Send an email to the identified person at the CME:

- 
2. CC the following persons:
    - a. Director, Child and Adolescent Mental
    - b. CME Director
    - c. The Regional Child and Adolescent representative(s) (listed below)
    - d. The Waiver Coordinators
    - e. The CBAY Child and Adolescent Specialist

3. The contents of the email should read:

(CME Name),

Please find attached the CBAY MFP packet for this Region (Where the child lives), (County of residence). (Name of child) has been accepted into CBAY MFP waiver effective (Budget date). Care Management has been authorized effective that date. To access billing for Family Support and Training, please notify me or your waiver coordinator via email which agency that will be providing this service.

The Consumer ID for this Referral is: (enter here)

Your Waiver Coordinator for this Referral is: (enter here).

If you have any difficulty opening the attached document, please notify me.

(Signature of sender)

4. Attach the zip file from the I drive.

## 8.0 Review Process

**1. Click Demographics- Note: Make sure that all paperwork (cover sheet, MDS, DRF, sign in sheet,) is accounted for if not then contact Wrap Supervisor to inform of missing documents.**

- a. Put in Last Name of Youth
- b. Click Team List Tab
- c. Print Team List (use for review purposes)
- d. Click Forms Tab
- e. Click Cover Sheet for CBAY Individualized Service Plans
- f. Click on the corresponding cover sheet (matching the email notification in CBAY Notifications)
- g. Approve the Cover Sheet
- h. Print the Cover Sheet
- i. Then click Back Button
- j. Click Forms Tab
- k. Click Document Review Form (DRF)
- l. Click on the corresponding DRF from Wrap Supervisor (WS)- check for completion & print

- 
- **If a non-required / Interim plan** (3 month, 4 month, 6 month, 7 month, 9 month, 10 month)
    - Interim plans are only reviewed by the CBAY Coordinator or the Health and Welfare Coordinator if there is a TPA request, a significant safety concern or an ECFTM.
  - m. If a required plan (14 days, 30 days, 2 month, 5 month, 8 month, 11 month, Discharge)
    - Click on Minimum Data Set (in Forms Tab)
    - Click on corresponding MDS- check for completion

**2. Click on Action Plan** **Note: Make notes of your review feedback so it can be recorded on the CBAY Coordinator's DRF.**

- a. Put in Last Name of Youth
- b. Click ACTION PLAN/Narrative Tab
- c. Click Print- Review in Pop up if the sign-in form is completed with youth, family, and team members present signatures
  - **If an Interim Plan (if not skip to “Click Strengths Tab”)**
    - Read ACTION PLAN Narrative in ACTION PLAN/ Narrative Tab
    - Review only the indicated Need Statement and Strategy which has been instructed to be indicated on the Cover Sheet for all Interim Plans
    - When completed Go to Demographics
    - Put in Last Name of Youth
    - Click on Forms Tab
    - Click on Interim DRF
    - Click on New Button
    - Complete a DRF with the Information Needed (Self-Explanatory)-  
**Note: Not all Interim plans require review of Safety & Crisis Plan this is at the discretion of team and state personnel.**
    - When completed enter the Action Plan Status number
      - For Responses 1, 2, 3, 5, 6, & 7 – Click Approve/Deny/Required Action Button & send email notification to the Wrap Supervisor so they are alerted that feedback is ready.
        - For Response 1
          - Send email notification to the Wrap Supervisor with indication of due date when paperwork will be expected
          - If not received by due date then response become a 7 then click Approve then click Print and File
          - Plan will not be reviewed until all proper documents are received. If documents are

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received within appropriate allotted time then the Plan can be approved with associated ACTION PLAN (see instructions to get back to this section)

- For Response 2
    - Plan Not reviewed due to no changes
  - For Response 4
    - Send email notification to the Wrap Supervisor with indication of due date when information will be expected
    - If not received by due date then response become a 7 then click Approve then click Print and File
      - Approve associated ACTION PLAN (see instructions to get back to this section)
    - If received in allotted time then change response then click Approve then click Print and File
      - Approve associated ACTION PLAN (see instructions to get back to this section)
- d. Click Strengths Tab- Review & Cross Reference with Team List Copy
- e. Click Domain Review Tab
- Click on Most Recent Domain Review folder corresponding with the plan you are reviewing- Note: If marked Medium or High then Explanation Required
- f. Click Vision Tab- Review
- g. Click ACTION PLAN/Narrative Tab
- Click on Most Recent ACTION PLAN folder corresponding with the plan you are reviewing
  - Read Narrative- Note: Make sure it is descriptive of meeting details and of youth's behaviors as well as any other needed updates (ie. Change of custody, change of team members, etc.
- h. Click Needs Tab
- Click each Need folder (do not review those indicated as *pending*)
    - Review the following sections in each Need folder:
      - Need Text (Need Statement)
      - Benchmarks (Expected Outcomes)
      - Strengths- Review which team members strengths are associated with this need

- o Strategies (Strategy Updates are required for each strategy unless it is a 14 day plan)
- i. After reviewing all Need Folders- Click on Demographics
- j. Put in Last Name of Youth
- k. Click on Forms Tab
  - Click DRF
  - Click New Button
  - Complete a DRF with the Information Needed (Self-Explanatory)
  - When completed enter the Action Plan Status number
    - For Responses 2, 3, 5, 6, & 7 – Click Approve Button & send email notification to the Wrap Supervisor so they are alerted that feedback is ready.
      - o For Response 1
        - Send email notification to the Wrap Supervisor with indication of due date when paperwork will be expected
        - If not received by due date then response become a 7 then click Approve then click Print and File
        - Approve associated ACTION PLAN (see instructions to get back to this section)
      - o For Response 4
        - Send email notification to the Wrap Supervisor with indication of due date when information will be expected
        - If not received by due date then response become a 7 then click Approve then click Print and File
          - Approve associated ACTION PLAN (see instructions to get back to this section)
        - If received in allotted time then change response then click Approve then click Print and File
          - Approve associated ACTION PLAN (see instructions to get back to this section)

**3. After completing all steps and approving ACTION PLAN & DRF**

- Go to Demographics
- Put in Last Name of Youth
- Go to Forms
- Go to MDS
- Click on Corresponding MDS
- Approve MDS (if appropriate)
- Print MDS

**4. Additional Enrollment Steps (MFP CBAY YOUTH ONLY)**

- a. Upon approval of the Action Plan Waiver Coordinator fills out MFP Authorization of Services document to include:

- 
- Pre – transition Care Management and Family Support Peer and approves services in PPL-TPA.
  - b. Waiver Coordinator uploads to FTP Site:
    - Enrollment Packet
    - 14 Day Action Plan
    - Discharge Day Checklist
    - Authorization for MFP Transition Services
  - c. Waiver Coordinator upload to FTP Site:
    - All required Quarterly Action Plans and Quarterly updated Authorizations for MFP Transition Services forms.
  - d. Waiver Coordinator upload to FTP Site:
    - Enrollment Status Change Form at day 365 or with other status changes during enrollment.
  - e. As Sentinel Events happen:
    - Health and Welfare Coordinator will upload Sentinel Event forms to FTP site within 72 hours of receipt from CME.

## **8.1 TPA PROCESS**

### **Complete New Budget Process/Enter MDS**

1. Open TPA (<https://fms.publicpartnerships.com/PPLPortal/Login.aspx>)
2. Enter user name and password login
3. Consumer search
4. Consumer Last name search
5. Referrals
6. Budget detail
7. Care coordination check provider
8. Family support Partner check provider
9. New budget
10. Create New budget
11. Budget detail
12. Create new service referral
13. Select Care Management
14. Select provider name
15. Enter note: Care Coordination
16. Add 3 Units and create

- 
17. Create new service referral
  18. Select family training and support services
  19. Select provider name
  20. Enter note: Family Training and Support
  21. Enter 240 units and create
  22. Back to consumer profile
  23. MDS Form
  24. Select budget period
  25. Enter MDS Form following formatted questions and save

## 8.2 MFP CBAY FORMS

### Complete MFP/CBAY Authorization for MFP Transition Services Form

1. Check Initial Authorization or Updated Authorization
2. Participant First Name, Last Name
3. Participant Medicaid ID#
4. Participant Date of Birth
5. Participant Address
6. Participant City and Zip Code Phone Number Other Contact Name
7. Anticipated Transition Date
8. COS Waiver Type MFP CBAY
9. Vendor will be DBHDD
10. **MFPCBAY /Pre Transition Services** - 1 Month of Services
11. Care Management 1 Unit(s) Authorized Dollars is \$721.05
12. Family Support and Training Services 80 Unit(s) Authorized Dollars \$1,662.40.
- **MFPCBAY Transition Services** 11 Months of continued services
13. Complete Pre-Transition Services portion only and dependent upon release of youth from PRTF within 29 Days . (To be completed with the 14 Day Action Plan).
14. Care Management 11 Unit(s) Authorized Dollars is \$7931.55
15. Family Support and Training Services 880 Units(s) Authorized Dollars \$18286.40
- **MFP CBAY Transition Services Portion** ( Quarterly Plan Review or Changes for TPA requests).(Please do not enter anything in the Post Transition Services portion).

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Complete the following Post Transition Services, which are to be reviewed quarterly and/or based on the need, Services are approved with prior authorization.

16. Behavioral Assistance Services
17. Respite Services
18. Customized Goods and Services (CAP \$ 2,000.00/Annual)
19. Supported Employment Services
20. Community Transition Services (CAP \$ 1,500.00 Annual)
21. Youth Peer Support Services
22. Clinical Consultative Services
23. Expressive Clinical Services
24. Transportation Services
25. Financial Support Services

Once Forms are Authorized by the CBAY Coordinator upload Form(s) to the FTP site

Upload the Following Action Plan(s) to the FTP Site:

- 14Day
- 1 Month
- 2 Month
- 5 Month
- 8 Month
- 11 Month
- Any Additional Interim Plans that are submitted for review due to changes.

#### **9.0 Denial, Reduction or Termination of Service**

CBAY Staff will follow processes and procedures as established in DBHDD Policy 01-105.

#### **10.0 Discharge Process**

1. In the 11 month plan the CME will notify the CBAY Coordinator via the MFP-CBAY Treatment Choice Form of the transition plans for discharge or graduation at the end of the current authorization. Complete the MFP - CBAY Treatment choice form for youth in CBAY. Complete the MFP Treatment Choice Form for youth participating

- 
- within the payment source Money Follows the Person. If youth discharging due to more than 30 consecutive days in a PRTF then following procedures will be completed.
- If MFP CBAY youth, a MFP Notice of Denial or Termination form will be completed and sent via certified mail from DBHDD in accordance with DBHDD Policy 01-105 and uploaded to the DCH FTP site.
  - If BIP or 1915c youth, a Notice of Denial or Termination form will be completed and sent via certified mail from DBHDD, in accordance with DBHDD Policy 01-105.
2. The CME will indicate in the Action Plan and the Action Plan notes that the team is planning discharge or graduation.
  3. The CME Wrap Supervisor will notify the assigned CBAY Coordinator via CBAY Notifications of the youth discharge.
  4. The wrap supervisor will need to submit the CBAY/Wraparound Discharge form into synthesis.
  5. The CBAY Coordinator will review the discharge form to assure accuracy and completion.
  6. The CBAY Coordinator will approve the discharge in synthesis and print the form.
  7. The CBAY Coordinator will access the ACTION PLAN tab in synthesis to make sure there are no Action Plans for the youth that are still not approved.
  8. The CBAY Coordinator will access the TPA site to edit the budget so that it will match the discharge date from the CME.
  9. The CBAY Coordinator will review for accuracy and complete the MDS completed and submitted by the CME in synthesis.
  10. The CBAY Coordinator will complete CBAY Discharge Checklist( Green form)

## 11.0 Quality Improvement

Continuous Quality Improvement (CQI) is the process by which we review the documentation of our efforts, and establish strategies for improvement in the service delivery process based on this review. All CME sites participate in a CQI process outlined by the CBAY/CME Quality Council, as documented in the CBAY/CME Quality Improvement Plan.

### Standards of Practice

- All sites will participate in the CBAY/CME Quality Council
- All sites will participate in the CME QA/Evaluation workgroup of the CBAY/CME Quality Council.
- The CME site will randomly select a sample of charts for review by the Peer Review Team.
- Feedback is provided to the site regarding the individual records selected (this feedback form remains in the chart) and feedback regarding general trends and summary of the

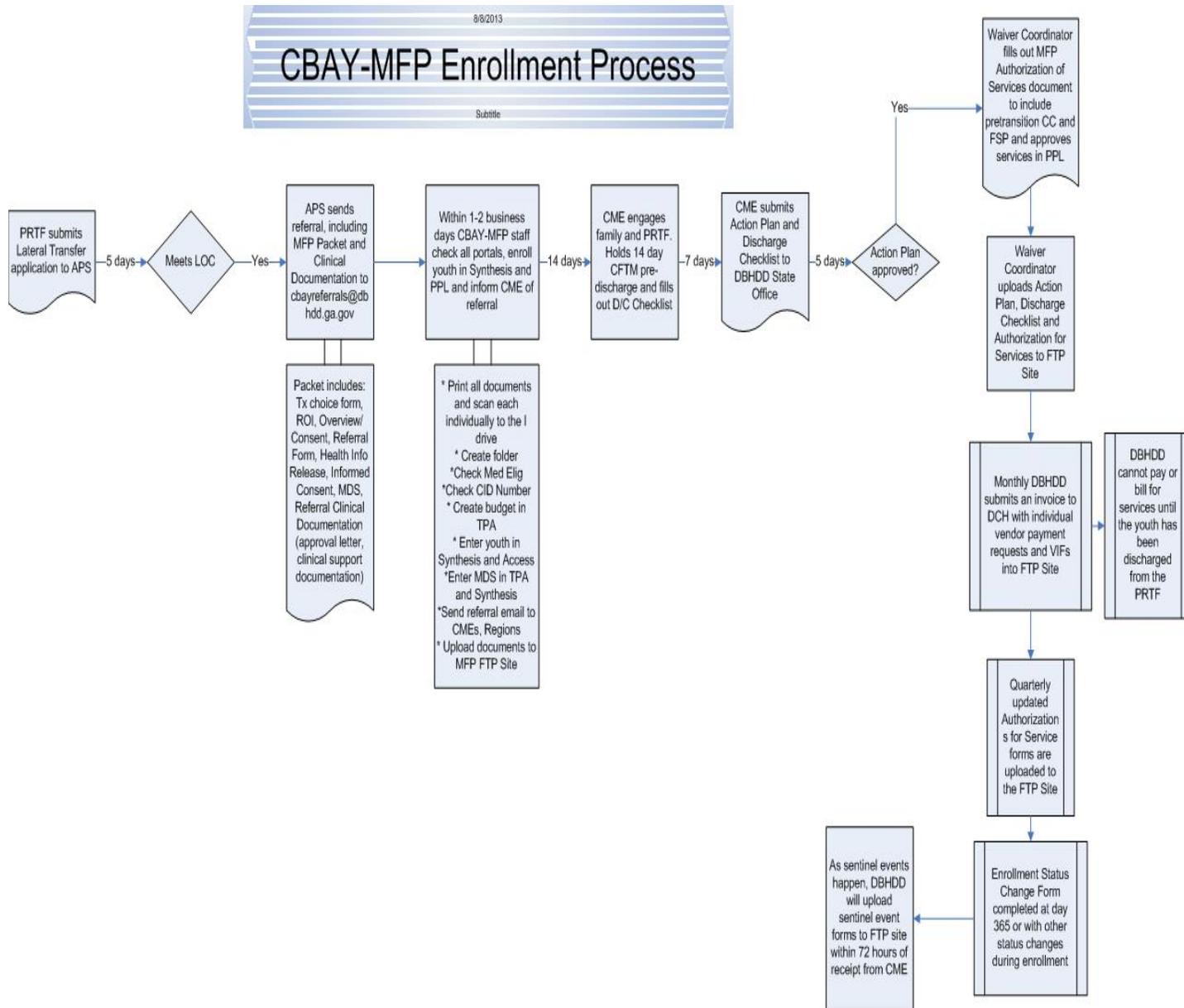
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review is provided to the CME Director. The Peer Review Team will use Wraparound Assessment forms to document the feedback and Corrective Action plans developed.

- All site review results are submitted to the State CBAY/CME Program Director within fifteen days of the audit.
- Sites should conduct regular internal audits of all active cases, including correction and feedback activities that are documented and managed by the CME Director.
- QA Staff should give an update on CQI results and trends to the CBAY/CME Quality Council QA/QI workgroup quarterly.
- Sites also participate in a semi-annual administrative review by the State Department of Behavioral Health and Developmental Disabilities to ensure that CME adheres to contractual obligations for fiscal reporting and use of contract funds for personnel, training and other site-specific activities.
- Will participate in all Quality Improvement, Evaluation, Training and Fidelity Monitoring Activities through the Center of Excellence, CHIPRA Grant or any other mechanism DBHDD chooses to utilize.

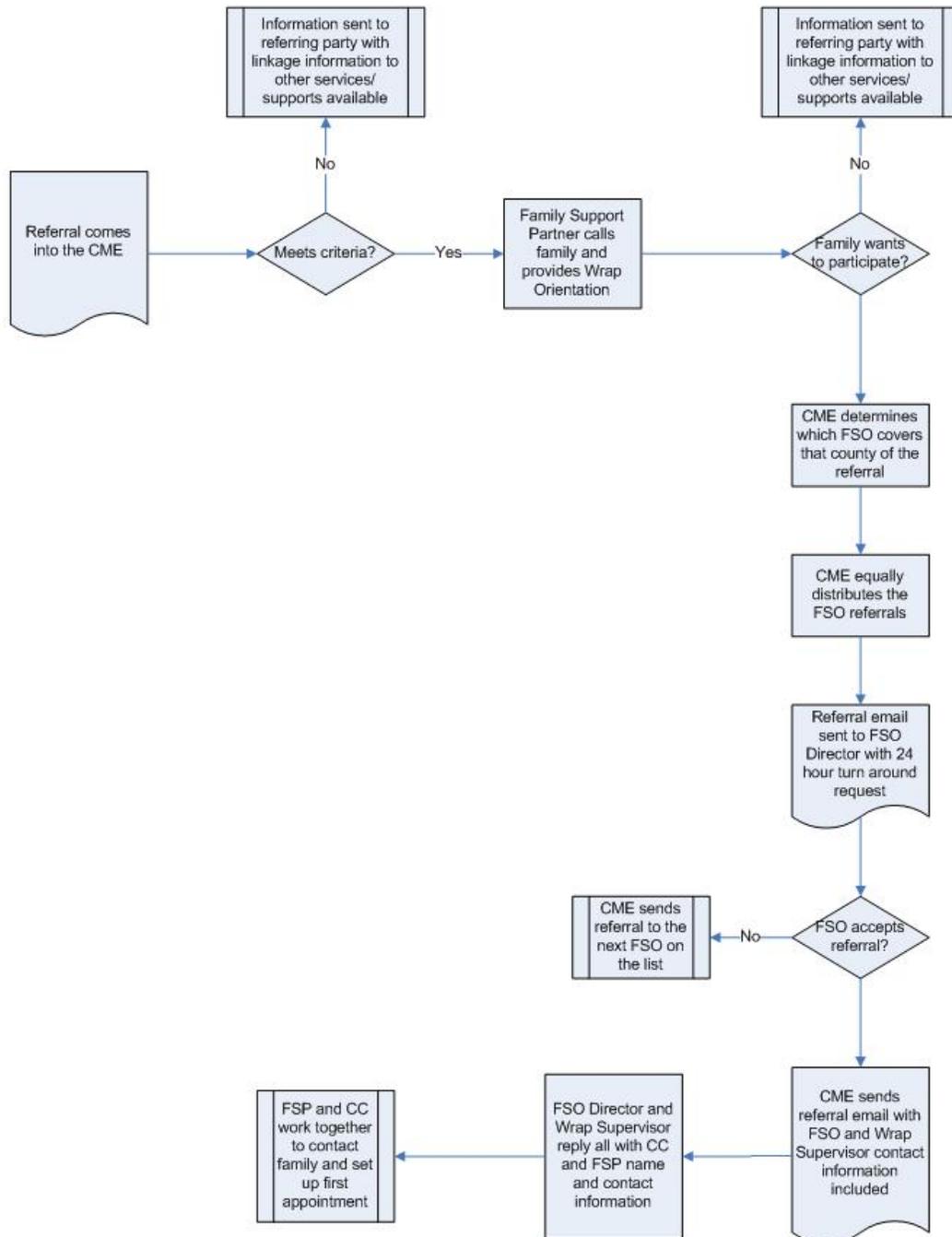
CMEs are subject to review by the Department of Community Health, and the Department of Behavioral Health and Developmental Disabilities, the DBHDD External Review Organization, Centers for Medicare and Medicaid Services, and the appropriate accreditation agency.

**APPENDIX A**



# CME/FSO REFERRAL PROCESS

TUESDAY, APRIL 02, 2013



**APPENDIX B**

# Wrap Team Minimum Communication Process

7/25/2013

