

REQUEST FOR APPLICATIONS

Emergency Department Diversion Program

Available Funds: \$1,683,000 in total, up to \$841,500 per award

Grant Period: October 15, 2008 through April 14, 2010

Budget Periods: 1: October 15, 2008 – April 14, 2009
2: April 15, 2009 – April 14, 2010

Applicants conference: July 28, 10:00 a.m.-12:30 p.m. CST
Illinois Primary Health Care Association,
500 S. 9th Street, Springfield, Illinois 62701

By phone at 877-402-9757, pass code 6407147#

To register, please call 217-557-1000

Applications Received: August 29, 2008 by 4:00 p.m. CST

Delivered to: IL Department of Healthcare and Family Services
Bureau of Healthcare Quality Improvement
607 E. Adams Street, 4th Floor
Springfield, IL 62701
217-557-1031

Label: Emergency Department Diversion Program

EMERGENCY DEPARTMENT DIVERSION PROGRAM

I. PURPOSE

Effective January 1, 2007, grant funds were authorized to establish alternate non-emergency services under Section 6043 of the Deficit Reduction Act of 2005, Public Law 109-171. Via funding opportunity HHS-2008-CMS-ANESP-0005 through the Department of Health and Human Services/Centers for Medicare and Medicaid Services, the Illinois Department of Healthcare and Family Services (HFS) received a grant. The grant is to implement an Emergency Department (ED) Diversion program that creates two collaborations between a community hospital, a federally qualified health center (FQHC) and a community mental health provider. One of the collaborations will be in the Chicago area and one will be in an area that serves persons from rural areas. The collaborations' mutual goal will be to serve HFS-enrolled beneficiaries seeking non-emergent care from a hospital emergency department in a non-emergent primary care and mental health setting.

To implement this federal grant, HFS is soliciting applications to make grants available to collaborations between:

1. Federally Qualified Health Centers (FQHCs),
2. Community mental health providers, and
3. Community hospitals.

This Request For Application (RFA) for two FQHC/community mental health provider/community hospital collaborations is being released for the purpose of expanding the service system's capacity to:

- Serve individuals in ways that improve HFS enrolled beneficiaries' access to primary care services outside of emergency departments, and
- Serve persons with mental illnesses in a peer¹-staffed crisis response program using innovative alternatives to emergency department and inpatient care.

Specifically, the purposes of the grants are to:

- Establish new FQHC sites on or near hospital campuses that will provide primary health care services to HFS-enrolled beneficiaries as an alternative when ED services are not warranted, and
- Implement 24/7 peer-staffed crisis response programs, with capacity for medical differential diagnostic services, acute medication management, and peer provided immediate crisis response support operated by a community mental health provider located near the new FQHC site and the hospital ED site.

Services for these purposes must commence by October 2009.

¹ An individual who meets the following three criteria (1) is living in recovery from a mental illness and possibly a substance use disorder and for the purposes of this grant could also have a comorbid chronic medical condition and (2) is employed or employable in the mental health treatment system delivering peer services and (3) will achieve the Certified Recovery Support Specialist credential through the Illinois Certification Board/IAOD APCA by the end of two years demonstrating the core competencies of recovery support.

Strong preference will be given to collaborations that:

1. Can add the capacity to provide, when necessary, overnight accommodations with peer-delivered crisis response service in settings that are as home-like and non-institutional as possible; and/or
2. Design and describe a process to deliver stage-based interventions to individuals with co-morbid addictive and mental illnesses. This preference will pertain when the collaborative service system offers:
 - Immediate access to the medically appropriate level of detoxification services, when necessary, with mental health and/or peer-provided supports, and
 - Seamless transition (immediate access) into subsequent, clinically appropriate substance use disorder and/or mental health treatment or both.

II. ELIGIBLE APPLICANTS

An eligible applicant for funding in response to this Request for Application (RFA) is a collaboration of the following for the purpose of the Emergency Department Diversion Project:

- A Federally Qualified Health Center (FQHC): An FQHC is a health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) (42 USC 1395x(aa)(3)) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Service Administration, U.S. Department of Health and Human Services.
- A Community Mental Health Provider certified under 59 Illinois Administrative Code 132 to provide Medicaid Community Mental Health Services.
- A community hospital with an emergency department that holds current CMS certification.²

III. APPLICANTS CONFERENCE

Applicants are invited to attend an Applicants conference:

July 28, 2008 from 10:00 a.m.-12:30 p.m. CST
Illinois Primary Health Care Association
500 S. 9th Street
Springfield, Illinois 62701

By phone at 877-402-9757, pass code 6407147#

To register, please call 217-557-1000

The purpose of the conference is to further explain the Emergency Department Diversion project grants and to describe HFS' vision for peer supported crisis response services as described in the

² Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.

Project Expectations section of this RFA. Attendance is not required for submission of a proposal, but is strongly recommended. The conference will not be recorded and available after the fact.

Questions may be submitted in advance via email to HFS.EDDiversio@illinois.gov. The deadline for advance questions is July 23, 2008 by 12:00 p.m. CST.

II. AVAILABILITY AND USE OF FUNDS

- A. Funding Level and Term:** A total of \$1,683,000 is available to fund two collaborations. Awards are expected to be announced by October 15, 2008. The term of the grant will be from the date of execution of the grant agreement through April 14, 2010. However, reporting requirements for the purpose of evaluation of the effectiveness of this grant will pertain beyond the end of the term of the agreement. The total grant award per collaboration is limited to \$841,500. There will be two budget periods within the grant period. Funding available for the first period, October 15, 2008 through April 14, 2009, will be \$710,250. Funding available for the second budget period, April 15, 2009 through April 14, 2010 will be \$131,250.
- B. Use of Grant Funds:** The two collaborations that receive an Emergency Department Diversion program grant may use grant funds to:
1. Construct or renovate space to serve the purpose of providing emergency department diversion services.
 2. Purchase equipment.
 3. Pay for program staff salaries and training³
 4. Enhance information technology.
 5. Purchase services or products that will facilitate the provision of urgent primary and mental health care services to HFS enrolled beneficiaries.
- C. Grant funds may not be used to:**
1. Offset existing debt.
 2. Supplant existing funds that support a particular service, program or activity for which grant funds are requested.
 3. Purchase real property (i.e., land and things permanently attached to the land).
 4. Provide services to non-HFS enrolled beneficiaries.

IV. PROJECT EXPECTATIONS

- A. Community Need:** Applications must demonstrate the following:
1. A community hospital collaborator treating a high volume of HFS enrolled beneficiaries with non-acute medical conditions in the emergency department.

³ NOTE: Technical assistance and training on the peer-supported crisis response model will be provided through consultants, engaged and paid by the State, on such topics as the recovery movement in mental health, use of peer staff and their role in the broader mental health treatment system, and the use of peer staff in integrated health care delivery to persons with serious mental illnesses. Consultants will be a predominant resource for the collaboration staff in the training and orientation of peer staff, employees and other relevant agency staff on the peer supported crisis response model.

2. Lack of availability of, or problems accessing or using primary and preventive services in the community after hours or on weekends.
3. Demonstrated use of the ED for non-acute mental health or substance abuse services.

B. Site Development

1. FQHC Site – Projects shall create a new FQHC site in collaboration with a community hospital, either within the hospital or in close proximity to the ED to increase the likelihood of smooth access to services between collaborating providers. This new FQHC site will require either:
 - a. An expansion of federal scope of project according to the U.S. Department of Health and Human Services Policy Information Notice 2008-01 or 2003-21, as applicable; or
 - b. Submission of an application for Section 330 funding. Projects that are managed by FQHC Look-Alikes must follow the most current guidelines set forth by the U.S. Department of Health and Human Services.
2. Peer-staffed Crisis Response Services Site – The peer-staffed crisis response services must be located in or in close proximity to the new FQHC and hospital site to increase the likelihood of smooth access to the services of each collaborating entity.

C. Services: Applicants must demonstrate the ability to provide the following:

1. Primary and preventive care services, including diagnosis and treatment of medical conditions not requiring ED services. Services will include interventions to expedite the development of a relationship with a medical home, education about the benefits of a primary medical home and referral arrangements as necessary.
2. Medical and psychiatric care that serves persons with the following types of needs:
 - a. Psychiatric, substance abuse and other medical co-morbidities.
 - b. Complex differential diagnostic services to ensure medical illnesses and substance abuse are not treated psychiatrically and vice versa.
3. Short-term peer-delivered crisis response intervention services in a more relaxing, less restrictive environment than EDs, and where persons can receive:
 - a. Recovery-oriented, peer provided crisis response services. (See Appendix A for links and resources about peer delivered services, the recovery movement and integrating consumers into the workforce.)
 - b. 23-hour bed capacity in a relaxing environment that is as home-like and non-institutional as possible)⁴
 - b. Psychiatric evaluation and treatment.
 - c. Nursing services, when necessary.

⁴ 23-hour hospital observation beds can be used to support extended interventions with individuals experiencing a mental health crisis. Hospitals can bill HFS for this service and are encouraged to work with community mental health staff to develop strategies to use these beds to provide extended peer staffed interventions.

Strong preference will be given to collaborations that add overnight capacity with innovative peer-staffed care, with accommodations in a relaxed setting that is as home-like and non-institutional as possible.

Additional preference points will be available to collaborations who describe a realistic plan to deliver stage-based interventions to persons with psychiatric/addiction co-morbidities that combine immediate access to the medically appropriate level of detoxification service (if needed) with seamless, immediate access to actual subsequent substance use disorder treatment. The requirement for seamless, immediate access to substance use disorder treatment pertains, for the purposes of this preference, irrespective of the necessity for detoxification.

D. Other Expectations

1. Grantees will train all staff in cultural competency and services will be delivered in a culturally sensitive and competent manner, with specific attention to a person's primary language and health literacy.
2. Grantees will demonstrate the ability to thoroughly attend to physical complaints and symptoms, irrespective of the degree of psychiatric symptomatology or length of time the person may have had a psychiatric diagnosis.
3. Collaborations will be expected to use the FQHC rates and Medicaid mental health fee-for-service rates currently in place, as applicable. FQHCs will bill HFS and community mental health providers will bill fee-for-service Medicaid mental health services to DHS/DMH.
4. Grantees will work with HFS to evaluate the impact of the program to determine its effectiveness and efficiency, including collecting data that will be used in an outcomes study.
5. Grantees will be expected to enter into an agreement to report information to the Department of Human Services/Division of Mental Health.
6. Grantees will submit interim progress and fiscal reports (actual time periods for reporting will be contractually defined and are dependent on the federal grant reporting periods) and at the end of each budget period. Forms and instructions for preparing and submitting these reports will be sent to the grantee shortly after the announcement of the two grant awards.
7. The services and programs developed using these funds will be maintained beyond the terms of financial support from this grant. References for program rules and billing procedures can be found in Appendix A.

V. SUBMISSION OF APPLICATION

Applications must be received no later than 4:00 p.m. August 29, 2008. Applications sent by fax will not be accepted.

An original application, signed by authorized individuals of the collaborating organizations, and five copies of the application should be sent directly to:

Stephanie Hanko
Illinois Department of Healthcare and Family Services
Bureau Healthcare Quality Improvement
607 E. Adams Street, 4th Floor
Springfield, IL 62701

Label: Emergency Department Diversion Program Proposal

VI. APPLICATION REVIEW PROCESS

A. Initial Review: Applications will be initially reviewed by HFS staff for eligibility and completeness. Applications must address all aspects of the Application Format section of this RFA, including the Summary, Memorandum of Agreement between co-applicants, all narrative sections, proposed budget, and letters of support regardless of points to be awarded. Applications determined to be ineligible or incomplete or unresponsive to any section will be returned to the applicant and will not be reviewed. A review committee will include, but is not limited to, individuals with backgrounds that include experience in health care, recovery oriented mental health care and peer supported service delivery.

B. Scoring: The following sections will be used for scoring:

- Community Need and Project Service Area 250 points
- Applicant and Service Description 250 points
- Site Development 250 points
- Objectives, Implementation Plan and Evaluation 250 points

Successful applications must score at least 700 of the 1000 points available across these four sections for award consideration.

C. Scoring for Optional Preferred Services:

The optional preferred services must be described within the sections listed above: Community Need and Project Service Area; Applicant and Service Description; Site Development; and Objectives, Implementation Plan and Evaluation. See Section III.B for the number of additional points for optional preferred services.

For additional information 217-557-1000 or e-mail at HFS.EDDiversions@illinois.gov.

**APPLICATION FORMAT
EMERGENCY DEPARTMENT (ED) DIVERSION PROGRAM**

The combined Project Summary and Project Narrative sections of the application must not exceed 30 double-spaced pages with one inch margins and a font size no less than 12 points. An additional 10 double-spaced pages may be added if preferences are applied for. Additional information related to the applicants or project should be included as an Attachment, including letters of support from community leaders. Please be aware that reviewers are not obligated to consider additional material not requested in this document.

I. PROJECT SUMMARY

Provide a brief description (1 to 2 pages) of the proposed project summarizing the community needs, service area and expected accomplishments. Include descriptions of financial, personnel and facility resources, both available and needed, for the project.

II. PROJECT NARRATIVE

The narrative must clearly and concisely address each of the sections below to thoroughly describe the proposed Emergency Department Diversion project. Do not assume that reviewers know your program or community.

A. Community Need and Project Service Area (250 points)

1. Provide statistics of ambulatory care sensitive conditions⁵ treated at the hospital collaborator's emergency department by top 20 diagnoses, number of visits per year for the past three years, and highlighting the time of day of visits (day, evening, weekend). Highlight behavioral health diagnoses and include similar statistics. Break these statistics out between HFS enrolled beneficiaries, unfunded individuals and individuals covered by all other payers.
2. Describe the specific needs of the community area this project would serve, the residents to be served by the ED Diversion project and the degree to which those needs are being met by the existing health care system in the area. Describe the methodology used to identify the need for the project. Be sure to describe the needs as it relates to HFS enrolled beneficiaries, unfunded individuals and individuals covered by all other payers.
3. Describe the availability of primary and preventive care after hours and weekends and what the FQHC and community mental health providers' hours of operation are currently.
4. Describe the economic and demographic characteristics of the identified service area.
5. Describe barriers to primary, mental health and substance abuse treatment care, such as the lack of public transportation, excessive distance or travel time to nearby service sites, insufficient numbers or lack of other health service providers.

⁵ Ambulatory Care Sensitive Conditions are defined as conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

6. Describe the primary health care system in the proposed service area, with particular emphasis on access to primary care services.
7. Describe the mental health and substance abuse treatment care system in the area, include a discussion of the level of integration of a recovery orientation⁶ and peer provided services in the mental health system in the area.
8. Identify the expected number of service area residents to be served by the ED Diversion project annually once the project is fully operational.

B. Applicant and Service Description (250 points)

1. Identify the collaborators for the ED Diversion project and fully describe the relationship between the community hospital, FQHC and community mental health provider in terms of both historical relationships and proposed collaboration.
2. Specify which collaborator will be the lead applicant and receive the grant money for the project. Include a description of how the money will be allocated to the collaborators to support the elements that each are developing and implementing during the grant term.
3. Describe how the collaborators will work together to deliver the services. Also describe how referrals and linkages to other entities for services will occur and how those linkages will be supported.
4. Identify which collaborator will be responsible for which services.
 - a. Address how the collaborators will develop operational procedures to ensure that an individual who needs access to different collaborators' services can receive them in a coordinated and seamless manner without being sent back to or through the hospital ED. In describing this, use the example of someone who has needs from a primary care provider, a specialty medical care provider at the hospital, and mental health care.
 - b. Define the anticipated hours of operation in the ED Diversion Project and any changes in referral processes after hours.
 - c. Describe the role the ED Diversion collaboration expects to play within the primary health care system and the mental health care and substance abuse treatment system in the service area.
 - d. Describe how individuals will be introduced to the FQHC primary medical care as the provider for urgent medical needs or to the peer provided services for mental health recovery support in urgent or crisis situations Describe how an individual will be introduced to peer-delivered crisis response services.
 - e. Describe how the triage system will be blind to insurance status when offering treatment in the FQHC.
 - f. Describe how differential diagnostic evaluations will assist in triaging persons who appear to have psychiatric or substance use symptoms and what systems will be implemented to encourage responsiveness to physical signs and symptoms reported by persons with mental or substance use illnesses.

⁶ Please see Appendix A for a link to the National Consensus Statement on Recovery.

- g. Discuss how the hospital based 23-hour beds, or other such alternative, using innovative peer-staffed crisis response services will be implemented. Refer to footnote 4.
 - h. Describe how coordination and linkage with the Screening, Assessment and Support Services (SASS) provider and other child/adolescent appropriate mental health services will occur. Appendix A includes references for the SASS program.
5. Describe the level of readiness of each collaborator to collaborate and implement the services for which they will be responsible.
 6. Include and discuss a staffing plan, a recruitment and retention plan, and a plan for how to train replacement staff due to turnover; include types and numbers of FTEs anticipated.
 7. Describe each collaborator's history, if any, of developing and/or providing new innovative services. Please describe each agency's history, or lack thereof, of implementing services that are developed, administered and monitored using a predominantly peer recovery support workforce and recovery orientation.
 8. Describe each collaborator's history, if any, of including mental health consumers in the provision of recovery support services and their participation in the administration, supervision, and evaluation of such services.

C. Site Development (250 points)

1. Describe the physical plant resources currently available to the ED Diversion collaboration.
4. Describe if any physical plant resources will need to be developed to support the FQHC and community mental health provider services. If so, detail what will need to be developed.
5. Describe the location of the ED Diversion Project site(s) and their physical relationship to the hospital and each other. Discuss how the site locations will facilitate smooth and integrated service delivery for individuals moving between each provider's services.
6. Describe how the proposed project will be integrated into any existing operations and any modifications needed to accommodate the operations.
7. Describe the plan for application for change of scope of services and potential impacts on revenue/expenses and operations.
8. Describe the plan for the application for and approval of any additional site certified under the 59 Illinois Administrative Code, Part 132.
9. Describe plans for health information technology implementation, including any anticipated linkages with collaborators.

D. Objectives, Implementation Plan, and Evaluation (250 points)

1. Identify measurable objectives the project proposes to achieve as a result of this grant.
2. Describe the implementation plan and a timetable to achieve the objectives.
3. Demonstrate that the new FQHC site will be operational by October 2009.

4. Discuss how services will continue to be sustained post-grant period. Include a discussion of how the new or additional services will be integrated into a providers' current array of services and sites. For example, how will a community mental health provider integrate an individual receiving peer staffed crisis response services into their larger array of already funded and developed services to develop a continuum of care for an individual; or, how will an FQHC integrate an individual into their primary medical care services or assist in linking the individual back to his/her medical home or finding specialty care services if needed.
5. Discuss, from a financial perspective, how the sites and services will be sustained post-grant. For each of the services, i.e., medical, psychiatric, peer-supported, peer-staffed 23-hour beds, explain funding and reimbursement assumptions.
6. If optional preferred services are applied for, discuss how the sites and services will be sustained post-grant. Explain expected patient-related revenue and other funding assumptions (remember that current HFS rates do not cover room and board).
7. Identify who will be responsible for project evaluation and describe the process to be used to document the project's progress in meeting the objectives described above.
8. Describe the process to be used to determine the efficiency of operations and effectiveness of the project in meeting service area needs.

III. OPTIONAL PREFERRED SERVICES

- A. Affirmation:** Applicants must affirm the desire to be considered for the optional preference points based on the collaboration's ability to:
- Add overnight capacity to the innovative peer-staffed crisis response ⁷ (i.e., to offer services for those persons requiring crisis services that extend beyond 23 hours), and/or
 - Deliver stage-based interventions to persons with psychiatric/addiction co-morbidity that combine immediate access to any medically appropriate level of detoxification service with subsequent seamless, immediate access to actual substance use disorder treatment.⁸
- B. Scoring:** To be considered for additional points due to the inclusion of optional preferred services, each element of Section II, Project Narrative must be addressed for each optional service the collaboration is proposing to provide. Preference scoring will be allocated as follows:

⁷ The overnight capacity differs from the service model known as Crisis Residential in IL in several respects. Chief among these is the expectation that (1) services are peer delivered (2) when overnight accommodation is part of this crisis response model, the accommodation lasts, on the average, 2-3 days or (3) it is to be expected that many of the individuals who use the peer provided crisis response service will have no need for the overnight accommodation.

⁸ This was previously referred to in the federal grant application as:

- “Enhanced short-term medically monitored detoxification services involving an overnight or longer non-hospital stay including integrated mental illness and substance abuse services and complex discharge planning.”
- “Short-term detoxification services”

- Overnight (i.e., 24+ hours) Capacity: An additional 160 points are available, with maximum possible allocation as follows:
 - a. Community Need and Project Service Area: 20 points
 - b. Applicant and Service Description: 70 points
 - c. Site Development: 40 points
 - d. Objectives, Implementation Plan, and Evaluation: 30 points

- For systems enhancements that offer immediate access to detoxification and treatment for substance use disorder, 40 additional points are available, with maximum possible allocation as follows:
 - a. Community Need and Project Service Area: 10 points
 - b. Applicant and Service Description: 15 points
 - c. Site Development: 5 points
 - d. Objectives, Implementation Plan, and Evaluation: 10 points

IV. PROJECT BUDGET

- A. Proposed Budget Expenditures:** Using the enclosed budget format, report the total dollar amount needed for the project by expenditure category per budget period. This page is not included in the proposal page limit.

- B. Other Revenue Sources:** Identify all revenue sources and amounts, including in kind contributions, other than those requested under this RFA that will be necessary to implement the proposed ED Diversion program. This page is not included in the proposal page limit.

- C. Budget Narrative:** Provide a thorough narrative description of all amounts included in the budget request. Describe the relationship between the funding request and project goals and objectives. The budget narrative is not included in the 30-page proposal limit.

V. ATTACHMENTS (Attachments are not included in the page limit)

- A. Attachment A: Letters of Support:** Letters of support for the expansion or new site should be included as Attachment A to the application. These letters should be from select community and consumer leaders. If ED physician services are furnished by contract, a letter of support from the physician group must be included.

- B. Attachment B: Description(s) of Proposed/Existing Contracts:** Documents that describe the planned relationships between the applicant organization and the other collaborators cited in the proposal should be included as Attachment B. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and any deliverables.

- C. Attachment C: Memorandum of Agreement:** An executed Memorandum of Agreement among the parties specifying the intent to jointly implement the

Emergency Department Diversion project, inclusive of each party's contribution to the project, and affirming the support of the application being submitted for the ED Diversion project must be included as Attachment C.

- D. Attachment D: Attestation of Understanding:** An attestation must be included as Attachment D showing a commitment to continue reporting beyond the term of the grant to the Departments of Healthcare and Family Services and Human Services/Division of Mental Health to allow for continued evaluation, along recovery parameters, of the interventions for persons with mental illnesses. Minimally the data will include clinical tools to evaluate consumer clinical needs at point of entry to peer support services and at point of discharge or shortly thereafter; interview or survey tools to assist in quality of life impact evaluation; and standard demographic and related data that community mental health providers would typically report to DHS/DMH.

APPLICANT INFORMATION SHEET

PROJECT TITLE: Emergency Department Diversion Program	
PROJECT PERIOD: October 15, 2008 to April 14, 2010	
AMOUNT REQUESTED:	
LEAD APPLICANT AGENCY (i.e., agency that will receive & administer grant funds):	
MAILING ADDRESS:	
PHONE:	
FAX:	
E-MAIL:	
LEAD APPLICANT FEIN NUMBER:	
LEAD APPLICANT IDHR NUMBER:	
LEAD APPLICANT PROJECT CONTACT NAME:	
ADDRESS:	
PHONE:	
FAX:	
E-MAIL:	
CO-APPLICANT AGENCY (i.e., agency collaborating with lead applicant to implement ED Diversion grant):	
MAILING ADDRESS:	
PHONE:	
FAX:	
E-MAIL:	
CO-APPLICANT AGENCY (i.e., agency collaborating with lead applicant to implement ED Diversion grant):	
MAILING ADDRESS:	
PHONE:	
FAX:	
E-MAIL:	
_____ LEAD APPLICANT AUTHORIZED SIGNATURE	_____ DATE
_____ CO-APPLICANT AUTHORIZED SIGNATURE	_____ DATE
_____ CO-APPLICANT AUTHORIZED SIGNATURE	_____ DATE

BUDGET PROPOSAL

A. PROJECT EXPENDITURES

Expenditure Category	Budget Period	
	Oct 15, 2008 - Apr 14, 2009	Apr15, 2009 - Apr 14, 2010
Personnel		
Fringe benefits		
Travel		
Supplies		
Equipment		
Construction/Renovation		
Contractual		
Other		
TOTAL		

B. PROJECT SUPPORT FROM SOURCES OTHER THAN REQUESTED GRANT FUNDS

Funding Source	Budget Period	
	Oct 15, 2008 - Apr 14, 2009	Apr 15, 2009 - Apr 14, 2010
Service revenues		
Other federal funds (specify)		
Other state funds (specify)		
Local funds (specify)		
Other sources: a. b. c.		
TOTAL		

Appendix A

DHHS/CMS Grant Narratives for Funded Grants:

<http://www.cms.hhs.gov/GrantsAlternaNonEmergServ/>

Screening, Assessment and Support Services (SASS): <http://hfs.illinois.gov/sass/>

HFS Hospital Handbook: Information regarding observation beds can be found in the HFS Hospital Handbook. You can obtain a hard copy of the Handbook by contacting the HFS Provider Participation Unit at 217-782-0538 (the Handbook is not currently available on the HFS web site).

FQHC Rules: <http://bphc.hrsa.gov/policy/> and <http://bphc.hrsa.gov/policy/pin9823/default.htm>

59 Illinois Administrative Code, Part 132, Medicaid Community Mental Health Services Program: <http://www.ilga.gov/commission/jcar/admincode/059/05900132sections.html>

Community Mental Health Service, Service Definition and Reimbursement Guide:

http://www.hfs.illinois.gov/assets/070107_cmph_guide.pdf

Integrated Dual Disorders Treatment:

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring>

PEER DELIVERED SERVICES RESOURCES AND ARTICLES

National Consensus Statement on Mental Health Recovery:

<http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>

Peers in the Workforce:

<http://www.behavioral.net/ME2/dirmod.asp?sid=9B6FFC446FF7486981EA3C0C3CCE4943&nm=Archives&type=Publishing&mod=Publications%3A%3AArticle&mid=64D490AC6A7D4FE1AEB453627F1A4A32&tier=4&id=0C618C2759AF48999307CB2437703175>

<http://www.freedom-center.org/pdf/peersupportdefined.pdf>

<http://www.bhrm.org/guidelines/salzer.pdf>

<http://www.azdhs.gov/bhs/guidance/peer.pdf>

<http://www.ilru.org/html/publications/newsletters/Briefs/Vol2Iss2.pdf>

<http://www.behavioral.net/ME2/dirmod.asp?sid=9B6FFC446FF7486981EA3C0C3CCE4943&nm=Archives&type=Publishing&mod=Publications%3A%3AArticle&mid=64D490AC6A7D4FE1AEB453627F1A4A32&tier=4&id=0C618C2759AF48999307CB2437703175>

Recovery Service Components: <http://www.recoveryinnovations.org/components.html>

Peer Provided ED Services: <http://www.recoveryinnovations.org/LivingRoom.pdf>

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

AUG 15 2007

SMDL #07-011

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Background on Policy Issue

States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

Delivery of Peer Support Services

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing

Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,



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