Below is an updated list of responses to some of the questions received by CSoC.Helpdesk@la.gov through April 7, 2011. Some questions require greater research or a decision by the Leadership Team, therefore may not be answered the week the question is received. New questions and answers are scheduled to be posted each Friday through May 13, 2011.

Questions Regarding Posting of Information

The CSoC Webinar "Provider Issues and Related Medicaid Requirements" is being held at the same time as the OBH technical assistance webinar for the RFA. I understand that the OBH Webcast will be viewable from the website, but it is not the same as being able to attend and submit questions in real time. While the PowerPoints from the CSoC Webinar series are being posted on the website, the audio/visual presentations are not being made available, and again the opportunity to post questions in real time is lost. Can you clarify so hat providers have access to attending all CSoC related training?

Answer:
The OBH technical assistance webinar is the *Provider Issues and related Medicaid information* webinar. They are the same thing. We are not aware of any other webinar at that time. The webinars are not available for in person attendance- only via telephone and on line. We intend to post the recording of the webinar on the CSoC Website

Will the PowerPoint presentations from the March 15 meeting be published?

Answer:
The PowerPoint has been posted on the CSoC website: www.dcfs.la.gov/csoc

Will the webinars be archived?

Answer:
Yes- the PowerPoint presentations will be posted on the CSoC website: www.dcfs.la.gov/csoc

Questions Regarding the Wraparound Agency

Will there be WAA/FSO training related to forming healthy relationships with the thousands of local churches and faith communities in Louisiana which are important natural supports? The CSoC may appear to some as a government-funded (and therefore frightening) initiative.

Answer:
OBH will develop a training plan that takes into consideration the roles of the WAA and FSO within the community.

I read in the CSoC Application that the Award Announcement date is in June and that the launch date is January 2011, when would staffing need to begin? Is the Wraparound agency required to hire 36 new employees?

Answer:
The business model projections assume that the agencies would begin staffing up one month prior to beginning to see clients. Then their caseloads would gradually increase over the course of the year. The recommended staffing for a WAA is in the RFA. The required staffing ratio for Wraparound Facilitators to children/families is 1 FTE staff to 10.

If a region's FSO and WAA are separate, independent nonprofit organizations, must their independent formation and incorporations be simultaneous for a regions' selection? It's very likely that a region may be interested and meet criteria, but not have all the corporate structures in place by the stated deadlines.

Answer:
As stated in the RFA, the FSO and WAA must be in incorporated and in operation by January 1 for start up implementation. They do not necessarily have to be incorporated at the date of submission of the response to the RFA, but the required information must be included in the response to demonstrate required criteria are met.

In the 3/15/11 RFA conference in Baton Rouge, Michelle Zabel stated that in one of the other states that has already implemented a CSoC (Maryland?), the providers within a region pooled resources to form a legal (corporate) entity to be the WAA for that region.

a. Would this be allowed in Louisiana provided all stakeholders within the WAA service area agree?
b. Would the founding providers be allowed to serve on the governing board of the WAA?

Answer:
a. yes
b. Providers may serve on the governing board so long as the requirement for family participation is met, majority of board members are not providers and strict conflict of interest policies are adopted by the board.

Can the wrap around agency be placed in one identified parish government if agreements are in place for provision of wraparound services for the residents of the other parishes?

Answer:
There is no prohibition against a local government agency serving as the wraparound agency as long as it does not have the authority to mandate service provision or refer to itself to provide services.

Can a provider that provides services in one region apply to be the Wraparound Agency in another region that they do not provide services in?

Answer:
This should be acceptable, with the understanding that there would be no ability for the agency to refer to itself for service provision. The agency will have to comply with CMS requirements for appropriate firewalls to prevent the ability to self refer, restrict

beneficiary choice, or not provide full and complete information to a beneficiary. It is also expected that CMS will require that the WAA staff be housed and supervised completely separately from the provider staff.

If my agency covers more than one region in the state and provides direct services in another region, would it prevent the agency in the region without direct services from applying as a Wraparound Agency in the CSoC?

Answer:
No, with the understanding that there would be no ability for the agency to refer to itself for service provision. The agency will have to comply with CMS requirements for appropriate firewalls to prevent the ability to self refer, restrict beneficiary choice, or not provide full and complete information to a beneficiary. It is also expected that CMS will required that the WAA staff be housed and supervised completely separately from the provider staff.

If the Wraparound agency was put in a Juvenile Planning Board, would there be a problem with the planning board receiving Medicaid reimbursement?

Answer:
Due to the mandatory composition of the Child and Youth Planning Boards, a potential conflict of interest exists for it to serve as the WAA and therefore the proposal would not be considered.

The RFA states that "Because of the inherent conflicts of interest that might arise if WAA's also provide the services they manage, WAA's will not also act as service providers." Can the WAA provide counseling and other services to children and their families who are not in the CSoC target population (youth under age 22 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement)?

Answer:
No, it is anticipated that children and youth in the CSoC target population will transition out of CSoC and into regular Medicaid behavioral health services or the adult system. Therefore a conflict of interest exists.

Will the WSS and FSO be required to be licensed either through DCFS or DHH? And if not, why would there be no licensing governance?

Answer:
WAAs and FSOs are not facility based programs and do not require licensure. Certification requirements will be developed by DHH as described in the RFA that the WAAs and FSOs must comply with in order to contract with the SMO and deliver services to the CSoC children and youth.

<u>Questions Regarding Regional Geographic Issues and Points of Contact</u>

Can Agencies from Jefferson and Orleans parish coordinate together to form one WAA? If so, does it matter where they seat the coordinating agency? Will the

coordinating agency be able to send WAA clients to participating agencies in the two parishes?

Answer:
If all stakeholders-- not just provider agencies-- agree and demonstrate commitment, Jefferson may participate with Region 1 (Orleans, Plaquemines, St. Bernard parishes). Jefferson and Orleans may not submit an application excluding Plaquemines and St. Bernard parishes. The WAA agency may have a physical office in any of the parishes, but staff must serve clients in the entire region over time.

Is Jefferson Parish excluded from participating in the INITIAL delivery of services under the new WAA or have they been assigned to any specific agency/agencies?

Answer:
Jefferson is not excluded; they are invited to submit an application to implement the CSoC either individually or as specified above, with Region 1.

How can I determine who is applying to be the lead agent for Region II?

Answer:
There is no lead agent for regional RFA responses. Each region is expected to organize its own key stakeholders to develop a collaborative response to the RFA. Those stakeholders who submitted an "Intent to Apply" email by 3/25 will be posted by region on the CSoC website with their contact information.

What is the process or who are the point of contacts for the FSO and WAA for Region 7? Is there a location on the website where this information can be obtained for all the regions throughout the state? Is there a calendar on the website with dates for when these meetings will be held in each region?

Answer:
FSO and WAA contacts participate in the larger community process for responding to the RFA. The contact information from all who responded by the March 25 deadline for the call for Notice of Intent to Apply will be posted on the CSoC website. Each region is responsible for organizing and publicizing its own meeting schedule.

<u>Questions Regarding CSoC Implementation and Services</u>

Given that foster families do not currently receive the full cost of caring for foster children will the CSoC enable Louisiana's DCFS to fully reimburse foster families the entire cost of providing care to foster children?

Answer:
For regular foster care board payments, the state has no current plans for increasing the rates provided to regular foster families. The CSoC will not govern regular foster care board payments. Routine annual budgetary consideration will continue with regard to the need for regular board rate increases.

It is my understanding that Behavioral Health contracts with providers funded through DOE, DSS, and OJJ that are paid with SGF dollars will be terminated and

the funds pooled under the new CSoC. When do you project that those contracts will be terminated?

Answer:
Many behavioral health services currently funded with state general funds will transition to become Medicaid reimbursable services as a result of an amendment to the Medicaid state plan and waiver applications. Most of these will go into effect when the new state plan is implemented, currently scheduled for January 1, 2012. If the contract held by a current provider includes these services, the provider will need to work to become a certified Medicaid provider and contract with the SMO. As the details of the implementation schedule become more defined, DCFS and OJJ will communicate directly with their existing provider networks to assist providers to make the transition to become Medicaid providers to deliver needed services.

How many of each residential bed type (PRTF, TGH) will be needed by the CSoC?

Answer:
We are initially planning for 250 youth to be served within PRTFs and a maximum of 322 TGH placements. The exact number of PRTF's and TGHs has not been determined; that will be done upon consideration of needs and location of youth requiring this level of care. More information on this will be available on April 20 at the State Residential Provider meeting

How will DCFS's current contracts for Independent Living services (Transitional Living programs and Life Skills Training services) fit into the CSoC's provider structure?

Answer:
DCFS will continue to provide the current contracted Independent/Transitional Living/Life Skills training for our youth in foster care through our contract providers in each region. These regularly provided services are not going to be part of the CSoC. However, the CSoC will potentially open up opportunities for enhanced services to youth with intense behavioral health needs.

In the Glossary of Key Terms and Acronyms as well as in footnote 17 on page 55 of the RFA the acronym "OLP" is used.

"17 Licensed Practitioner of the Healing Arts: Under Medicaid regulations, medical necessity for rehabilitative services must be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law, and they must be furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level. This is generally held to be a physician or licensed practitioner (see the OLP definition) acting in his or her scope – but not every practitioner (e.g., LPC or LAC) can do everything under their scope."

There is no definition for OLP in the Glossary of Key Terms and Acronyms and no further explanation of what is meant by "but not every practitioner (e.g., LPC or

LAC) can do everything under their scope." Please explain what limitations will be place on practitioners and give a rationale for limiting the scope of practice under certain practice licenses within the CsoC. This directly relates to how a Region may assess readiness and gaps in services. For instance, in Region 9 there are very few practicing psychiatrists and/or psychologists. If a physician or psychologist is necessary to determine medical necessity, then this would certainly be a gap in the region. However, if other LMPs are able to assess medical necessity as is determined by their scope of practice such as LCSWs, LPCs, or LMFTs, then this would not be a gap in the region.

Answer:
The Federal definition is found at 42 CFR 440.60 Medical or other remedial care provided by licensed practitioners. "Medical care or any other type remedial care provided by licensed practitioners" means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law.

In Louisiana, 42 CFR 440.60 includes the following:
A licensed mental health practitioner (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently:

§ Medical Psychologists
§ Licensed Psychologists
§ Licensed Clinical Social Workers (LCSWs)
§ Licensed Professional Counselors (LPCs)
§ Licensed Marriage and Family Therapists (LMFTs)
§ Licensed Addiction Counselors (LACs)
§ Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. In addition, they may not be debarred, suspended, or otherwise excluded from participating in procurement activities under the State and Federal laws, regulations, and policies including the Federal Acquisition Regulation, Executive Order No.12549, and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the Federal Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and Federal laws, regulations, and policies may not participate.

All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice

under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental health counseling and may not use appraisal instruments, devices or procedures for the purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities, or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers. Per the State's practice act and consistent with State Medicaid Regulation, Medical and Licensed Psychologists may supervise up to two Clinical Psychologists.

Inpatient hospital visits are limited to those ordered by the individual's physician. Visits to nursing facility are allowed for psychologists if a PASRR (Preadmission Screening and Resident Review) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Visit and may not be billed separately. Visits to ICF-MR facilities are non-covered. All LMHP services provided while a person is a resident of an IMD such as a free standing psychiatric hospital or psychiatric residential treatment facility are content of the institutional service and not otherwise reimbursable by Medicaid. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by DHH. A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

Please note however, that the independent practitioner must be enrolled with the Statewide Management Organization (SMO). Medicaid beneficiaries may choose to access services through any network provider who provides the appropriate level of care.

The SMO contractor is required to contract with providers of behavioral health services who are appropriately licensed and/or certified and meet the state of Louisiana credentialing criteria, who agree to the standard contract provisions, and who wish to participate. The SMO contractor is required to provide at least as much access to services as exist within Medicaid's fee for service program. Within the Plan's provider network, recipients have a choice of the providers which offer the appropriate level of care. Rehabilitation providers must be employed by a rehabilitation agency, school, or clinic licensed and/or certified and authorized under State law to provide these services. Rehabilitation Agencies must be certified by the Department of Health and Hospitals. Mental health clinics must meet the licensure standards for psychiatric facilities providing clinic services as determined by the Bureau of Health Services Financing, Health Standards Section. The SMO will be encouraged to collaboratively develop networks with service accessibility and required to sub-contract with providers necessary to fill any service gaps existing in the SMO.

Enrollees will have free choice of providers within the SMO and may change providers as often as desired. If an individual joins the SMO and is already established with a provider who is not a member of the network, the Louisiana SMO will make every effort to arrange for the consumer to continue with the same provider if the consumer so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. In addition, if an enrollee needs a specialized service that is not available through the network, the SMO will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, enrollees will be given the choice between at least two providers. Exceptions would involve highly specialized services which are usually available through only one agency in the geographic area. .

In addition, consistent with requirements in 42 CFR 438 and because of historic quality of care behavioral issues in the State, the Statewide Management Organization (SMO) must have credentialing and recredentialing policies consistent with federal and state regulations. The SMO must evaluate every prospective subcontractor's ability to perform the activities to be delegated prior to contracting with any provider or subcontractor. The SMO is not obligated to contract with any provider unable to meet contractual standards. In addition, the SMO is not obligated to continue to contract with a provider who does not provide high quality services or who demonstrates utilization of services that are an outlier compared to peer providers with similarly acute populations and/or compared to the expectations of the SMO and State. The SMO's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The SMO must have a written contract that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation, terminating contracts, or imposing other sanctions if the subcontractor's performance is inadequate.

The SMO must monitor all subcontractors' performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The SMO must identify deficiencies or areas for improvement, and the subcontractor must take corrective action.

When will applications for providers be available outside of the WAA applications?

Answer
If you are asking how to enroll as provider to offer the Coordinated System of Care services as well as other Medicaid and non-Medicaid funded services, the details have not been finalized. At this time, it is expected the process will include a certification process developed and implemented through a partnership between the state of Louisiana and the Statewide Management Organization (SMO). Current and potential providers will be offered training and support prior to implementation. The SMO is expected to begin offering training in late summer or early fall 2011. Refer back to the CSoC website or the Department of Health and Hospitals, www.dhh.la.gov for more details

Once the CSOC is in place next year, will agencies that provide Medicaid funded services still be able to accept referrals directly from schools, clients, etc... or will all referrals have to go thru the wrap around agency?

Answer:
Although clients are encouraged to freely choose among available providers/agencies, the accepting agency the referral must be enrolled/approved by the SMO, meet pre-established quality and access standards, and all services provided must be prior authorized by the SMO. Once the CSOC and other state plan services are in place, the process for accepting referrals, performing assessments and required treatment planning will differ, depending on the client’s eligibility and age. All state plan services for those 21 years old or younger must be authorized/reauthorized by the SMO. For those eligible for the CSOC services (including wraparound planning), all services must be approved by the Wraparound Agency or the SMO. For those 22 years of age or older, an

independent assessment and plan of care must be established prior to being approved by the SMO to receive designated services. For children outside of the CSoC, they must have a service plan developed, which will be approved by the SMO for all rehabilitation services (unlicensed staff) and authorization by the SMO for services provided by licensed staff.

The criteria in the 1915c waiver states "meets criteria for psychiatric hospitalization placement" which is very different than at risk of out of home placement criteria in the RFA, for example, homeless, foster care or detention. Will the youth the meeting the target population automatically meet criteria or will they also have to meet criteria for psychiatric hospitalization?

Answer:
The target population for CSoC is broader than just children eligible for Medicaid financing. The CSoC target population is children and youth with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement defined as:

- Addiction facilities,
- Alternative schools,
- Detention,
- Developmental disabilities facilities,
- Foster care,
- Homeless as identified by DOE,
- Psychiatric hospitals,
- Residential treatment facilities, and
- Secure care facilities

The Child and Adolescent Needs Assessment will be the assessment tool utilized to determine if a child or youth meets the criteria for the CSoC target population and includes identifying children at risk for additional out of home placements, not just those who meet criteria for psychiatric hospitalization.

The 1915(c) waiver is a contract with the federal government regarding the Medicaid financing of certain services for Medicaid eligible children in Louisiana. Some limited services will be financed through Medicaid if a child within the CSoC meets certain institutional criteria (e.g., psychiatric hospitalization and nursing facility criteria).

I am writing to ascertain any information that you may be able to provide concerning the services in the Coordinated System of Care. I would like to know if you can provide me a web link or any specific information on the definition of crisis intervention services and/or case management services as may be covered in the CSoC.

Answer
The service definitions are still being developed and are not available for distribution at this time. Please refer back to the CSOC website in the next 60 days.

In a question last week, the answer referenced not being able to waitlist people in one region when capacity exists in another. Does this mean "slots" may be reallocated from one region to another if not being used?

Answer:
While we do not expect any region to serve less than 240 children/youth when fully implementing the CSoC, federal Medicaid requires that the slots are allocated on a statewide basis in the 1915(c) Medicaid waiver. So if there are 480 "slots" allocated in the first year of the program for two participating regions, if there are 250 children in one region and 230 children in another region, CMS will require the State to accommodate the 480 children regardless of their region.

A psychiatric treatment model is, by definition, focused on the amelioration of a narrow portion of a patient's physiological and behavioral health needs. The CSoC's documents describe a philosophical approach incorporating holism, or the concern for a patient's whole being. What are the particular techniques the CSoC seeks to implement to meet the requirements of this philosophical stance and allow providers to deliver care in an holistic manner?

Answer:
The CSoC is seeking to support four primary types of interventions through this RFA. These interventions are described throughout the RFA, and the RFA must be viewed as a whole when defining them (including web links to additional documentation). Specific pages in the RFA that offer key definitional material for each are provided below.

1. A System of Care: See pp 14-15 of the RFA for key definitional material.
2. Wraparound Facilitation: See pp 16-18 of the RFA for key definitional material.
3. Youth Support and Training: See pp 70-71 of the RFA for key definitional material.
4. Parent Support and Training: See pp 71-72 of the RFA for key definitional material.

What are the benefits a region accrues by applying to be a first implementer?

Answer:
First round implementing regions will benefit by serving children and youth and improving outcomes earlier and potentially in greater number cumulatively over time.

What percentage of the 3:1 Medicaid-funding the CSoC will bring into Louisiana will be spent on new organizational structures versus the provision of direct services to children?

Answer:
There will be administrative costs associated with CSoC implementation but those have not been finalized. A goal of the CSoC is to streamline administrative costs through coordination and reduced duplication across the four agencies enhancing service effectiveness.

How many jobs is the CSoC expected to create in Louisiana given that each of nine regions is expected to have at least one WAA and one FSO?
With the formation and staffing of the 20 new nonprofits required to implement the CSoC, what is the final ratio of all CSoC staff to participating children expected to be after full implementation has been achieved across Louisiana?

Answer
FSOs and WAAs may be new corporations or existing corporations meeting the mandated criteria. They may hire new staff or transition existing staff into new roles. Full implementation is expected to serve a minimum of 2,400 children per year, but expansion is expected as need and capacity is assessed over time. A ratio of CSoC staff to children/youth served is impossible to calculate at this time.

If a region is not chosen as one of the initial site or if they are not ready to apply by May 13th, when will they be able to apply? Will there be another RFA or can they apply as soon as they are ready?

Answer
The details of phase 2 implementation have not yet been determined, however the current budget projects round 2 regions implementing in FY 12/13

We were told that each region will only be able to serve 248 children. Is this accurate? What happens with subsequent children that are referred? Obviously they will receive any services they can outside of CSoC, but will they be put on a waiting list with the WAA and picked up when another child is discharged from CSoC? Or are they just rejected? Is it possible for a region to serve more than 248 children in a year? Will that number increase if it is shown to be lower than the number of kids who qualify and need CSoC services?

Answer:
It is not anticipated that more than 240 children/youth per region would be identified as needing CSoC services in year 1. If more children in a single region than the 240 children that can be staffed by the FSO and WAA are found eligible for the CSoC in year 1, then the SMO will be expected to provide Treatment Planning and waiver services for any Medicaid child eligible for CSoC. The State Governance Board will monitor access to services and direct expansion or changes to CSoC implementation, including any amendments to the waivers as needed. However, in no circumstance is the SMO/State allowed to waitlist children in one region if there is capacity in another region or statewide due to federal prohibitions on rationing medical care for eligible children by region within a state.

If an out of home placement for a CSoC eligible child is deemed necessary and authorized by the SMO, can family support services still be available to the family members and reimbursed?

Answer:
Yes

Please clarify whether the FSO for a region will be utilizing other family support services of non-profits to complement FSO services (not duplicate). There are many service providers in the community that provide supportive services to families, but would not be the FSO. Will these agencies be a referral resource for WAA plan of care or will the services of the non-FSO agencies be excluded.

Answer:
Only FSOs identified through the RFA process and contracted with the SMO may deliver and be paid for "Youth/Family Support and Training" as described in the RFA. Other services and natural supports (including family support groups and other supports provided by other non-profit agencies) will be determined as needed by the family and youth through the Child and Family Team planning process.

If I currently operate an OJJ Tracker/Mentor service how does this RFA affect the service I provide for the state? Should I consider becoming a part of this process?

Answer:
All community stakeholders are encouraged to become involved in the RFA process currently underway in local communities. It is important the community and potential WAA and FSO be aware of existing service providers. It is also important that service providers have knowledge of the process through which youth will navigate the coordinated system of care and were providers have the potential to interact with CSoC.

All eligible providers are also encouraged to begin educating themselves about the process of becoming eligible for Medicaid services. You can find additional information on the DHH website at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1568 Of particular importance to providers is to monitor the statewide management organization (SMO) development. Once that statewide entity is chosen through the RFP process, learn how to become connected to the SMO for referrals.

For existing OJJ contracts, if your service becomes a Medicaid billable service, you must become eligible to bill Medicaid and register with the SMO. For non Medicaid eligible services, the contracting process with OJJ will remain the same. It is possible once the new system is in place, the mentor and tracker services will be contracted separately. In that situation, mentor services may be Medicaid eligible and contract through the SMO and tracker services will remain contracted with through OJJ. As these decisions are made, the information will be communicated directly to existing providers.

Please clarify whether transportation services is reimbursable for the CSoC services. Transportation is a major barrier for many families seeking services. There may be some home-based services offered, but may not be possible for all services specified in the plan of care.

Answer:
Children and Youth in the Medicaid will have access to standard Medicaid transportation services for services under the State Plan including services by licensed and unlicensed practitioners.

Questions regarding Governance

Is the Department of Education acquiring real "buy in" from a significant number of the parish school boards?

Answer:
School districts have not been able to recover costs for behavioral health services in the past. At times like this when fiscal planning and responsibility are equal to the challenges of student accountability, the "buy in" to be reimbursed for services rendered and the opportunity to collaborate with community providers is being very well received.

Will the CSoC ensure that funds received by local and parish school boards for the provision of school-based behavioral health services will be used only for those services and not disbursed among other school-based programs or initiatives? If yes, then how will this oversight occur?

Answer:
Policy guidelines to address this issue are currently being discussed. As we move closer to 1/1/2012 start-up date, school district personnel will receive training as needed to appropriately implement all aspects of the CSoC.

On the Governance Board application under the qualifications section it says that the advocate cannot have staff overseeing activities as part of the system of care. This basically means that if Goodwill has someone who is interested in applying, we cannot be involved in any other aspects of CSOC. Do I understand this correctly?

Answer:
The intent is to minimize conflicts of interest, therefore if an advocate is a member of the Governance Board, then the advocate may not participate in any decision regarding the agency employing the advocate doing business or contracting in CSoC implementation.

Will any legislation be introduced during the 2011 Regular Session relative to the implementation of the CSoC? If so, what will that legislation attempt to do?

Answer
We do not anticipate filing legislation to support the CSoC implementation at this time.

How will the FY 2011/12 Executive Budget, to be presented on March 11, reflect the implementation of the CSoC? Where will it be referenced in the budget?

Answer:
The CSoC is reflected in DHH's Medicaid budget expenditures and included in the Interagency Transfer amounts within the DCFS, OJJ and DHH OBH budgets.

Currently, the MacArthur and Anne E. Casey Foundations are engaged in juvenile justice and detention center reform efforts respectively in LA. <u>Both propose to accomplish the same outcomes and serve the same at risk youth as does the CSoC by creating coordinated service delivery systems</u>. Have these initiatives been incorporated into the CSoC planning and proposed service delivery system?

a. ***If not, are we at risk of having several systems of care each duplicating the efforts of the CSoC, competing to serve the same at risk youth, and creating a new method of duplicating services and fragmentation of services?***

Answer:
The Leadership Team is looking at all programs and initiatives to build partnerships and collaborate with CSoC implementation.

Questions Regarding Family Support Organizations

An agency wishing to be considered as a FSO has non-profit and for-profit parts of the same agency. Can an agency be considered as a FSO if it has a for-profit part of the agency that is currently providing services? The FSO would be the non-profit part of the agency.

Answer:
If the FSO is affiliated with a an agency providing services in the CSoC, there would be a conflict of interest.

At the Webinar on 3/30/11 it was mentioned that the rate of reimbursement per 15-minute unit of service provided by the FSOs is anticipated to be $10.00. What is the anticipated lower and upper range of units/client/week that will be approved for reimbursement?

Answer:
As stated in the RFA, for planning purposes, the following service delivery assumptions went into the development of the rates. When at full capacity (and fully staffed per the requirements in Section 5.H):

Each FSO will serve a caseload of 240 children and their families:

- 15% of the children and youth will access Youth Support and Training - Individual for an average of 2.0 hours per week
- 100% of the families of enrolled youth will access Parent Support and Training - Individual for an average of 1.5 hours per week, and
- 100% of the families of enrolled youth will access Parent Support and Training - Group for an average of 2.0 hours per week.

Will a Family Service Organization be permitted to maintain offices in the facilities of a provider?

Answer
This may create a perceived conflict of interest, therefore It is preferred that the FSO not have its primary corporate location housed within a service provider