Texas 1115 Medicaid Demonstration Waiver: Review of 4-Year Behavioral Health Projects

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Texas Institute for Excellence in Mental Health

Advancing Resilience and Recovery in Systems of Care

Project Leads:

Molly Lopez, Ph.D.
Stacey Stevens-Manser, Ph.D.

Project Reviewers:

Tina Adkins, M.A., M.S.
Wendy Brooks, M.A.
Jodi Christianson, M.S.
Pamela Daggett, M.R.A.
Han Ren, M.Ed.
Vonzo Tolbert

Contact:

Texas Institute for Excellence in Mental Health
School of Social Work
University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703
Phone: (512) 232-0614
Fax: (512) 232-0617
http://blogs.utexas.edu/mental-health-institute/

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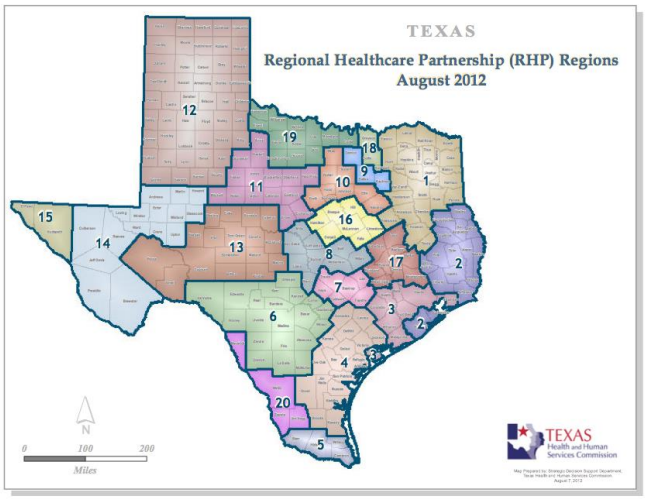
Introduction

In December 2011, the Texas Health and Human Services Commission (HHSC), serving as the state's Medicaid authority, received approval for an 1115(a) Medicaid Demonstration Waiver. The 1115 Medicaid Waiver allowed for the expansion of the STAR and STAR+PLUS managed care programs and created two pools of funding to support health care in the state – an uncompensated care pool and a Delivery System Reform Incentive Payment (DSRIP) pool. The DSRIP pool is intended to allow health care entities to implement new practices or programs to increase access to care, enhance the quality of care, or provide more cost-effective health care. The DSRIP component of the 1115 Demonstration Waiver introduces a quality-based payment system for health care providers and creates incentives for service provision in the most appropriate service setting.

HHSC divided the state into 20 regional healthcare partnerships (RHP), with each region anchored by a public hospital or other governmental entity. A list of the counties included in each regional healthcare partnership is available in Appendix A. Each region conducted a community needs assessment and engaged in collaborative planning to identify and prioritize health care projects that could be the most transformative for the region. DSRIP activities were organized into four categories:



- Category 1 Infrastructure Development - lay the foundation for the transformation through investment in staff, space, processes, and technology;
- Category 2 Program Innovation and Redesign - pilot or replicate innovative care models;
- Category 3 Quality Improvements - identify outcomes in which major improvements can be tracked and achieved based on the impact from Category 1 and 2 projects; and
- Category 4 Population-Based Metrics – develop measures that are reported by hospitals in all RHPs.

In December 2012, each RHP submitted project proposals to HHSC for state review. Proposals were then submitted for review to the Centers for Medicare and Medicaid Services (CMS). CMS approved a proportion of the proposals and required either technical or valuation changes to others. RHPs were allowed to make adjustments to their proposals for resubmission to CMS.

Many regions identified access to behavioral health care and the provision of behavioral health services in more costly settings (e.g., Emergency Departments, jails) as significant areas of concern. HHSC initially received over 1,300 proposals for 4-year DSRIP projects, and a significant number of these projects aimed to improve behavioral health care. Many stakeholders expressed an interest in understanding more about the behavioral health projects that have been approved, as this was seen as an area of innovation both within Texas and nationally.

Goals of the Project

In July 2013, the Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin School of Social Work, through a contract with the Meadows Foundation, began a review and analysis of the behavioral health proposals. The focus of the review is on Category 1 and 2 projects, as these represent the transformational changes to the service system, while Category 3 and 4 efforts represent the measurement of the outcomes resulting from the change projects. The Meadows Mental Health Policy Institute (MMHPI) provided support and consultation on the effort.

The goals of the 1115 Medicaid Waiver behavioral health review were to:

- Identify variables that best describe key characteristics of the behavioral health DSRIP projects;
- Develop a descriptive database of behavioral health projects that can be used by state agencies and other stakeholders;
- Summarize the activities that are planned across the state, including commonalities across multiple projects and areas of innovation; and
- Provide recommendations for opportunities for collaboration, sharing, and evaluation.

Methodology

Sources of Information

To submit their RHP plans for approval, each RHP prepared a document summarizing their unique community needs assessment and planning process and identifying their proposed projects. RHPs were limited to 10 pages for each proposed Category 1 or 2 project and followed a standard template. The templates requested information on the provider, the population to be served, the goal of the project and project activities, related projects, and the methodology for the proposed valuation of the projects. Each proposal also included metrics and milestones for each project year, from which incentive payments were based. HHSC initially posted the RHP proposals between February and April 2013 on the agency website. Subsequent to that, approximately half of the proposals required revision based on CMS review, and these proposals were revised through September 2013 to obtain initial CMS approval. TIEMH utilized this CMS-approved version of the proposals for review. These proposals represent the planning that had occurred at the time the proposal was written. The review does not reflect many changes that have been made to the projects since September 2013, including plan modifications and technical changes. The review did incorporate negotiated changes to potential incentive payments for demonstration years 2 and 3 (finalized July 2014), with estimated payments for demonstration years 4 and 5. The review also incorporated revised Category 3 outcome measure selections for each project, which were finalized in August 2014.

The 1115 projects are rapidly evolving over time. Negotiated modifications with HHSC are ongoing, and any summary of projects reflects only a point in time. Many proposals discussed utilizing the initial project year to conduct gap analyses, identify best practices, and gather stakeholder input to the initiative. Therefore, the information represented in this review reflects primarily the information available in these initial plans and does not capture additional project specificity that is likely to have occurred during the initial project period.

Sample

Category 1 and 2 projects were included in the review if they targeted individuals with behavioral health disorders or the behavioral health workforce. For this review, behavioral health included mental health and substance use conditions. The sample was identified through several methods intended to maximize identification of relevant behavioral health projects. HHSC identified the initial set of behavioral health projects. Several project options specifically focused on behavioral health care and these were included in the sample. In addition, many were led by public behavioral health agencies and could be identified through the provider name. TIEMH identified several additional projects based on a text search of terms, such as "behavioral" or "mental" or "substance". A few projects required consensus discussion with HHSC to determine if the project should be considered "behavioral health." Ultimately, 395 projects were included in the sample described in this report, all of which received approval by CMS. The sample does not include 3-year projects, which were submitted for approval after the initiation of the 4-year projects.

Database Structure

An initial set of variables was developed based on information included in the proposals and those thought to be most relevant to behavioral health projects. This list of variables was reviewed by HHSC and MMHPI staff and modifications were made based on this feedback. The database was pilot tested with five initial projects, reviewed by multiple reviewers, and additional suggestions were made to clarify definitions of variables or allow for multiple entries. The final database was developed in the REDCap system, a secure web-based application for research management. Each variable was defined briefly in REDCap, providing reviewers guidance on coding. REDCap allows data to be exported in a variety of formats.

Reliability Processes

Seven individuals with an understanding of the behavioral health system were tasked with reviewing the proposals and coding variables, under supervision of the lead investigators. Reviewers participated in an initial training to become familiar with the dataset and variables. Each reviewer then reviewed the same five proposals, chosen to ensure variety in the types of projects and potentially different information provided by RHPs. The coding for these projects was compared across reviewers, and variables with less reliable coding were identified. Additional definitions were provided in the database for select variables, and a second training was held to clarify definitional issues. Following this training, proposals were assigned to each reviewer for coding. Reviewers were able to indicate when coding decisions were unclear based on information provided in the proposal, and they could place notes in the database to reflect the information that they relied upon. Each proposal was then reviewed a second time by one of the lead investigators to ensure reliability and address unclear responses. Finally, a subset of variables for each proposal was sent to the RHP anchor contact for review and corrections if needed. This review by the RHP or provider occurred in two waves, with the review of the proposals approved in the first round occurring in December 2013 and the review of the final round of proposals occurring in June 2014. Response rates were 49% for the December review and 53% for the review occurring in June. The variables that were reviewed by the RHPs are noted in Appendix B.

Data Quality

Although processes were in place to improve the reliability of the dataset, not all variables were explicitly stated in all proposals, for example, the specific number and type of new staff to be hired. This should not be considered a fault of the proposal, merely that the review was focused on information that was not required in the brief proposal template. When data could be relatively clearly assumed, the reviewers coded it based on their best judgment and understanding of the behavioral health systems in Texas. When reviewers lacked information to make these assumptions, variables were labeled as "unclear" or "missing". It should be noted that the same project may be represented more than once in the database, as some providers serve a region that crosses more than one RHP.

Results

Overview

A total of 395 DSRIP projects were identified that addressed behavioral health care, which represented just over 30% of all DSRIP projects. Each of the 20 RHPs submitted behavioral health projects; however, regions differed in the number of approved behavioral health projects. In general, RHPs representing urban areas submitted more behavioral health projects than those RHPs representing rural areas. Region 3, which includes Harris County, had the greatest number of behavioral health proposals (46), representing 30% of all 1115 projects in the RHP. This was followed by other urban areas, including Region 7 (Austin and surrounding counties) with 37 proposals and Region 6 (San Antonio and surrounding counties) with 35 proposals. Among urban RHPs, Region 9 (Dallas) and Region 15 (El Paso) had the lowest percentage of behavioral health proposals (18.3% and 15.1% respectively). Relatively few behavioral health proposals were submitted by West Texas regions 14, 15, and 20 and by Region 17 in the Bryan/College Station area (6 to 8 proposals each). Table 1 presents the proportion of behavioral health projects in each regional health partnership.

Table 1. Proportion of 1115 Projects with Behavioral Health Component

RHP	Partnership Anchor	Total # of RHP Projects	Total # BH Projects	% of All Plans with BH Component
1	University of Texas Health Science Center - Tyler	95	24	25.3%
2	University of Texas Medical Branch at Galveston	75	30	40.0%
3	Harris County Hospital District	153	46	30.1%
4	Nueces County Hospital District	87	22	25.3%
5	Hidalgo County (South Texas)	34	18	52.9%
6	University Health System (San Antonio)	114	35	30.7%
7	Healthcare District (Austin)	66	37	56.1%
8	Texas A&M Health Science Center (Round Rock)	37	25	67.6%
9	Dallas County Hospital District	115	21	18.3%
10	JPS Health Network (Ft. Worth)	102	26	25.5%
11	Palo Pinto General Hospital (Mineral Wells)	42	10	31.4%

12	Lubbock County Hospital District	86	20	23.3%
13	McCulloch County Hospital District (Brady)	35	11	31.4%
14	Medical Center Health System (Odessa)	50	6	12.0%
15	University Medical Center of El Paso	53	8	15.1%
16	Coryell Memorial Hospital (Gatesville)	32	15	46.9%
17	Texas A&M Health Science Center (College Station)	29	8	27.6%
18	Collin County (Collin, Grayson & Rockwall)	23	16	69.6%
19	Electra Hospital District (Electra)	37	10	27.0%
20	Webb County Indigent Health Care Services (Laredo)	14	7	50.0%
All	All RHPs	1280	395	30.9%

Proposals were submitted within two categories developed by HHSC and approved by CMS: Infrastructure Development (Category 1) and Program Innovation and Redesign (Category 2). (Note that Categories 3 and 4 reflected performance outcome measures for Category 1 and 2 projects and outcomes reported by hospitals in the region). Categories 1 and 2 also had a menu of HHSC and CMS-approved project goal descriptions. Slightly more proposals were submitted under the Category 2 Program Innovation and Redesign goal (51.6%), which included a variety of projects targeting special populations (e.g., homeless, co-occurring mental health and substance use, and veterans' services). The most common Category 2 goal description selected was to "provide an intervention for a targeted behavioral health population to prevent unnecessary services in other settings" (54.4%).

Infrastructure Development (Category 1) included projects that expand capacity within local mental health authorities (LMHAs) beyond the targeted priority population, that establish clinics in additional locations, or that add services not currently provided. "Enhancing service availability to appropriate levels of behavioral health care" was the most frequently identified goal description (30.4%) within Category 1. Table 2 summarizes the project goals and number of projects identifying each goal.

Table 2. Categorization of Project Goal

	Number of Projects	Percent
All Category 1 Projects	191	48.4%
Category 1 - Goal Number and Description		
1.12 Enhance service availability to appropriate levels of BH care	58	30.4%
1.13 Development of BH crisis stabilization services	49	25.7%
1.9 Expand specialty care	29	15.2%
1.11 Implement technology assisted services to support or deliver BH services	21	11.0%
1.7 Introduce, expand, or enhance telemedicine/health	18	9.4%
1.14 Develop workforce enhancement initiatives to support access to BH providers in underserved areas	6	3.1%
1.10 Enhance performance improvement and reporting capacity	5	2.6%

1.1 Expand primary care capacity	4	2.1%
1.3 Implement a chronic disease management registry	1	0.5%
All Category 2 Projects	204	51.6%
Category 2 – Goal Number and Description		
2.13 Provide an intervention for a targeted BH population to prevent unnecessary services in other settings	90	54.4%
2.15 Integrate primary and BH care services	49	24.0%
2.18 Recruit, train, and support consumers of MH services to provide peer support services	15	6.4%
2.19 Develop care management function that integrates PH and BH needs of individuals	13	6.4%
2.17 Establish improvements in care transition from the inpatient setting for MH/SA patients	9	4.4%
2.9 Establish/expand a patient care navigation program	8	3.9%
2.2 Expand chronic care management models	4	2.5%
2.16 Provide virtual psychiatric and clinical guidance to PCPs delivering BH care	4	2.0%
2.6 Implement evidence-based health promotion programs	2	1.0%
2.1 Enhance/expand medical homes	1	0.5%
2.3 Redesign primary care	1	0.5%
2.4 Redesign to improve patient experience	1	0.5%
2.7 Implement evidence-based disease prevention programs	1	0.5%
2.8 Apply process improvement methodology to improve quality/efficiency	1	0.5%
2.12 Implement/expand care transitions programs	1	0.5%

Note: BH=behavioral health; MH=mental health; SA=substance abuse/use

Population of Focus

Age. The vast majority of projects targeted a general adult population (*n*=359; 90.9%) and a subset of these projects also included children (*n*=124; 34.5%). In some situations, it was unclear whether children were included or excluded (*n*=35; 9.7%). A small group of projects (*n*=29; 7.3%) focused exclusively on a general child population. Only a few projects targeted more narrow age ranges, with 11 (2.8%) targeting older adults (65 years or older), 2 (0.5%) targeting transition age youth (age 18 to 25), 6 (1.5%) targeting adolescents (age 12 to 17), and 4 (1.0%) targeting early childhood (age 0 to 5).

Types of Behavioral Health Issues or Populations. The majority of projects focus on individuals with the most serious mental health needs, with fewer targeting individuals with mild or moderate impairment. Projects were most likely to focus on individuals with severe mental illness (*n*=263; 66.6%) or serious emotional disturbance (*n*=98; 24.8%). Severe mental illness is a term utilized with the adult population and serious emotional disturbance is defined for a child and adolescent population. One hundred twenty-nine projects (32.7%) focused on the general mental health population [i.e., not severe mental illness (SMI) or serious emotional disturbance (SED)] and 101 (25.6%) focused on a population with substance use problems. Several sub-populations were also a focus of some proposals, with 75 (19.0%) targeting medical populations, 38 (9.6%) focused on intellectual or developmental disabilities, and 26 (6.6%) on

individuals with autism. Additionally, 18 projects (4.6%) focused on the homeless population, 26 (6.6%) on a criminal justice population, and 7 (1.8%) on veterans. Three projects (0.8%) targeted high utilizers of emergency care, inclusive of those with behavioral health disorders.

Table 3. Populations of Focus for Behavioral Health Projects

Population	Number of Projects	Percent*
Targeted Age		
General adult population excluding children	235	59.5%
General adult population and children	124	31.4%
Children only	29	7.3%
Older adults (65 and older)	11	2.8%
Adolescents (12 to 17)	6	1.5%
Transition age young adults (18 to 25)	2	0.5%
Early childhood (0 to 5)	4	1.0%
Behavioral Issue or Specialty Populations		
Severe mental illness	263	66.6%
Serious emotional disturbance	98	24.8%
General mental health (non-SMI/SED)	129	32.7%
Substance use problems	101	25.6%
Medical populations	75	19.0%
Intellectual or developmental disabilities	38	9.6%
Autism	26	6.6%
Homeless population	18	4.6%
Criminal justice population	26	6.6%
Veterans	7	1.8%
High utilizers of emergency care (not specific to BH)	3	0.8%

Settings of Care

The proposed setting of the health care innovation provides additional information about the nature of the projects. Table 4 provides information on the various service settings in which the behavioral health projects occur. Many projects were collaborative and included more than one health care provider or service setting. The most frequent collaborations were between a LMHA and a primary care clinic (*n*=21) or between a LMHA and a general hospital (*n*=20). In some cases, service providers were based in a clinic location, which was the setting reflected in the categorization, but actual services were being provided in consumer/client homes or other community settings.

Table 4. Settings for Behavioral Health Care

Service Setting	Number of Projects	Percent*
Local Mental Health Authority (LMHA)	303	76.7%
General Medical Hospital	59	14.9%
Primary Care Clinic (non-FQHC)	54	13.7%
General Medical Hospital – Psychiatric Unit	15	3.8%
Federally Qualified Health Clinic (FQHC)	13	3.3%

Mental Health Clinic (non-LMHA)	11	2.8%
School	10	2.5%
Psychiatric Hospital	8	2.0%
Substance Abuse Clinic (non-LMHA)	8	2.0%
Homeless Shelter/Facility	7	1.8%
County Health and/or Human Services	4	1.0%
County Jail	3	0.8%
Inpatient Detoxification Facility	3	0.8%
Ambulatory Detoxification Clinic	2	0.5%
Mobile Clinic	2	0.5%

Note: *Total is >100% reflecting collaborations between more than one provider or service setting.

New Staffing

The majority of projects indicated the need to recruit and hire new staff to support project goals. For some projects, recruitment of new staff was the primary activity intended to expand access to behavioral health care or other relevant services; therefore, staffing can be critical to the success of many projects. Because the specific type and number of staff were not required in the proposal template, it was sometimes unclear if new staff would be hired, but 303 (76.5%) of the projects appeared to plan for additional staffing. Licensed mental health practitioners, such as psychologists, professional counselors, and licensed social workers, were the most commonly identified personnel (38.0%). While other professional providers, such as psychiatrists, nurses, and bachelor's-level mental health providers, were also common, a significant minority of projects (*n*=38; 12.7%) planned to expand their peer workforce (*n*=42; 13.9%) or utilize community health workers or promotoras (*n*=13; 4.3%). Given current healthcare workforce shortages, particularly in behavioral health, the ability to recruit and hire new staff may affect the project timelines and outcomes. Project staffing is described in Table 5.

Table 5. Types of New Staff/Providers Identified in Projects

Staffing	Number of Projects	Percent
Licensed Mental Health Practitioner (Psychologist, LPC, LMSW, LCSW)	115	38.0%
Psychiatrist(s)	77	25.4%
Nurse(s)	61	20.1%
Administrative staff	60	19.8%
Qualified Mental Health Practitioner	55	18.2%
Peer Specialist	38	12.5%
Physician(s) (non-psychiatrist)	31	10.2%
Licensed Chemical Dependency Counselor	30	9.9%
Advanced Nurse Practitioner	28	9.2%
Community Health Worker or Promotoro/a	13	4.3%
Certified Behavior Analyst	10	3.3%
Patient Navigators or Care Coordinators	10	3.3%
Health Information Technology or data analysis staff	7	2.3%

Telepresenters	6	2.0%
Law enforcement professionals	5	1.7%
University faculty	5	1.7%
Family Partner (parent peer support provider)	4	1.3%

Evidence-Based and Promising Practices

Some proposals targeted specific interventions identified as empirically-supported or promising practices. Almost half of the projects (*n*=173; 43.8%) identified implementing or utilizing one or more evidence-based or promising practices. Thirty-three proposals (19.1% of the 173) stated that the evidence-based practice would be selected during the initial planning year. The twenty most commonly identified practices were:

- Cognitive Behavioral Therapy
- Cognitive Processing Therapy
- Supported Employment
- Applied Behavior Analysis
- Motivational Interviewing
- Wellness Recovery Action Planning
- Wraparound Planning
- Illness Management and Recovery
- SBIRT
- Collaborative Care
- Assertive Community Treatment
- Recovery Supports
- Whole Health and Resilience
- Seeking Safety
- Integrated Dual Diagnosis Treatment
- IMPACT
- Whole Health Action Management
- Chronic Care Model
- In SHAPE
- Cognitive Adaptive Training

A full list of all practices identified and the number of proposals planning to utilize those practices are provided in Appendix C. Although several proposals discussed plans for training staff in the evidence-based or promising practices, none discussed specific strategies for monitoring fidelity, leaving it unclear whether this will be a part of implementation efforts. Although addressing practice fidelity was not a requirement in the proposal template, some providers indicated a plan to monitor fidelity to the evidence-based practice during the data review period, and examining this aspect of project implementation may be useful in understanding project results and outcomes.

There are a wide variety of practices identified for implementation; however the most commonly chosen interventions were those currently supported by the public mental health system within existing performance contracts. With the exception of Applied Behavior Analysis, the practices that are most frequently represented are supported by training through DSHS. Some of the novel therapies that are being introduced into the system by one or more providers include Dialectical Behavior Therapy, Multisystemic Therapy, Cognitive Adaptive Training, and Cognitive Enhancement Therapy. Several novel programs focused on improving the health and wellness of a behavioral health population are also being piloted, such as Whole Health Action Management (WHAM), Individualized Self Health Action Planning for Empowerment (In SHAPE), Diabetes Empowerment Education Program, and chronic care management programs. The whole health programs were sometimes accompanied by hiring of peer specialist staff to deliver the intervention (for example, WHAM and Whole Health and Resilience are peer-delivered services). In addition to well-established models such as Motivational Interviewing, innovative substance use programs are also represented, such as The Matrix Model and Motivational Enhancement Therapy.

Common Project Categories

There are three areas in which many projects could be categorized, and those project areas are described in more detail in order to understand some of the commonalities and differences. These project areas include integrated care, technology enhancement, and crisis services.

Integrated Care

Table 6 summarizes project foci on populations with one or multiple health-related issues. The majority of projects include a focus on a singular population, such as mental health (*n*=238; 60.3%), substance use (*n*=63; 15.9%), or Intellectual or Developmental Disabilities (IDD; *n*=14; 3.5%). However, many projects planned to target individuals with co-occurring conditions to improve access to coordinated and integrated care.

Table 6. Project Focus

Project Focus	Number of Projects	Percent*
Mental health only	238	60.3%
Co-occurring behavioral health and physical health	139	34.9%
Co-occurring mental health and substance use	82	20.8%
Unspecified behavioral health	65	16.5%
Substance use disorders only	63	15.9%
Co-occurring intellectual or developmental disorders and behavioral health	33	8.4%
Intellectual or developmental disorders only	14	3.5%
Co-occurring intellectual or developmental disorders and physical health	8	2.0%

*Projects can target both a singular population and co-occurring populations, therefore the total can be greater than 100%.

The most common proposals for integrated care focus on co-occurring behavioral health and physical health conditions (*n*=139; 35.4%). Projects can be further described by examining the Four-Quadrant Clinical Integration Model (Mauer, 2009), which describes the population to be served in terms of the complexity of health and behavioral health conditions. The model is further illustrated in Appendix D. While most projects focused on only one quadrant, 36.0% focused on multiple quadrants of the model. Table 7 illustrates the frequency by which projects focused on each quadrant, reflecting the population, settings, and level of integration.

Most integrated behavioral health and physical health proposals focused on a population with significant behavioral health conditions, but fairly low intensity physical health needs (Quadrant II; *n*=87; 62.6%). The most common example of this model is placing a primary care physician or nurse within a public mental health setting to address the primary health care needs of individuals with serious mental health conditions. Other projects were more evenly distributed across the other three quadrants. Thirty-four projects (24.5%) include a focus on Quadrant I, which represents low behavioral health and physical health care needs. Hiring a care manager to engage individuals being treated for depression and monitor treatment outcomes within primary care would be an example of this model. A similar proportion of projects (*n*=39; 28.1%) focused on Quadrant III for individuals with low behavioral health needs and high physical

health issues. An example project is providing behavioral health consultation within the acute hospital setting to identify and address behavioral health needs. Lastly, a slightly larger proportion of projects (*n*=43; 30.9%) focused on individuals with significant behavioral health and physical health needs, identified as Quadrant IV. Examples of projects in this quadrant include integration of services within the emergency department and the provision of navigation services for individuals who are high utilizers of acute behavioral health and medical care services.

Integrated mental health and substance use treatment was identified in 20.8% of projects (*n*=82), and these projects were also categorized into the four-quadrant model (see Appendix E). The most frequently represented quadrants included Quadrant II with high mental health need and low substance use need (*n*=44; 53.7%) and Quadrant IV with high mental health need and high substance use need (*n*=44; 53.7%). Example projects include partial hospitalization with transitional services to lower levels of care. The other two quadrants were also represented within the projects, with 15 projects in Quadrant I (low mental health, low substance use; 18.3%) often focusing on screening for behavioral health concerns in primary care and 21 projects in Quadrant III (low mental health, high substance use; 25.6%).

Table 7. Integrated Care Quadrants

Project Focus	Number of Projects	Percent
Co-occurring behavioral health and physical health	*n*=139	
Quadrant I (Low BH / Low PH)	34	24.5%
Quadrant II (High BH / Low PH)	87	62.6%
Quadrant III (Low BH / High PH)	39	28.1%
Quadrant IV (High BH / High PH)	43	30.9%
Co-occurring mental health and substance use	*n*=82	
Quadrant I (Low MH / Low SA)	15	18.3%
Quadrant II (High MH / Low SA)	44	53.7%
Quadrant III (Low MH / High SA)	21	25.6%
Quadrant IV (High MH / High SA)	44	53.7%

There were a number of innovative projects focused on integrating services for select populations. Within behavioral and physical health integration, one unique project focused on providing psychiatric consultation 24 hours per day and 7 days per week to primary care physicians and medical hospitals within the region. One unique project focused on individuals with co-occurring mental health and substance use disorders will provide ambulatory detoxification for individuals transitioning from psychiatric hospitalization. There are also several unique initiatives focused on providing services to individuals with intellectual or developmental disorders (IDD), autism, and co-occurring behavioral health conditions. Several programs created specialized mobile crisis teams to provide crisis services to individuals with these comorbidities, while others develop specialized crisis respite programs or high intensity team-based models, based on Assertive Community Treatment or wraparound.

Technology Enhancement

Enhancement of technology to improve health care was described in 140 proposals (35.4%). The majority of the technology projects focused on developing, expanding, or using a telemedicine or telehealth system (*n*=85; 60.7%) to expand access to behavioral health services. Many projects targeted purchasing or upgrading of equipment and others included hiring and training additional staff to provide care through telehealth systems. A small percentage of all of these telehealth projects were primarily intended for physical health (*n*=6; 7.1%) but included behavioral services as well, with the majority targeting primarily behavioral health (*n*=79; 92.9%). Some projects planned to expand existing telehealth systems to additional regions in an effort to expand access geographically, while others incorporated telehealth across different settings, such as placement in jails, emergency rooms, or primary care clinics to enhance access to behavioral health specialists. Providers are also using telehealth systems to provide consultation by behavioral health experts to medical staff.

Additional technology projects involve the development or enhancement of electronic health records (*n*=39; 27.9%), with the majority serving as a behavioral health medical record primarily (*n*=24; 61.9%). Many of the projects enhancing electronic health records are working to integrate physical health care into the behavioral health record or facilitate integration across collaborating partners. Some additional projects (*n*=20; 14.3%) focus on developing data portals to allow data sharing across health care or other systems. These include projects focused on identifying high utilizers of emergency care to target specialized care navigation services or assisting with transition of individuals from hospital or jail-based care to the community. Several other unique and innovative technology projects were also noted, including the development of a data tracking systems, data dashboards, electronic communication systems, social media outreach campaigns, and testing the use of a computer-based treatment intervention for individuals living with schizophrenia.

Table 8. Types of Technology-Involved Projects

Service Setting	Number of Projects *n*=140	Percent
Telehealth	85	60.7%
Electronic Health Record – Primarily Medical	6	4.3%
Electronic Health Record – Primarily Behavioral Health	79	56.4%
Data Portals or data sharing platforms	20	14.3%

Crisis Services

A fairly large proportion of projects are focused on improving behavioral health crisis services (*n*=113; 28.5%). Regions chose a variety of strategies for improving the crisis system, with crisis respite programs being the most common (*n*=31; 27.4%). Crisis respite programs provide temporary short-term residential placement outside of an individual's usual living situation with the goal of resolving a crisis. This option was closely followed in frequency by mobile crisis outreach teams (*n*=28; 24.8%) and crisis stabilization programs (*n*=27; 23.9%). Crisis stabilization programs provide short-term residential treatment in a secure and clinically staffed, psychiatrically supervised, treatment environment. Crisis telehealth services were also planned for 27 projects (23.9%), and psychiatric consultation within emergency rooms or inpatient

medical services was proposed in 8 projects (7.1%). Crisis triage or assessment centers were proposed in 6 projects (5.3%), and urgent care clinics or psychiatric emergency centers are planned in 7 projects (6.2%). Other unique crisis projects represented in the DSRIP projects are crisis-focused ACT teams, peer provided crisis services, extended observation, and in-home crisis supervision. Although most of the crisis services targeted a broad population, some are planned for specialty populations, such as individuals with intellectual or developmental disorders, high risk youth at risk of out of home placement, or homeless individuals.

Table 9. Projects Involving Crisis Services

Type of Service	Number of Projects *n*=113	Percent
Crisis respite	31	27.4%
Mobile crisis outreach teams	28	24.8%
Crisis stabilization programs	27	23.9%
Crisis telehealth	27	23.9%
Psychiatric consultation in emergency settings	8	7.1%
Crisis triage or assessment centers	7	6.2%
Psychiatric emergency centers or urgent clinics	7	6.2%

Client Impact (Number of People to Be Served)

The calculation of client impact from the behavioral health DSRIP projects is challenging, as lead organizations identified impact in a variety of ways. Some proposals measured impact in unique individuals served, but others utilized patient visits, available beds, or providers entering the workforce. Many DSRIP projects are intended to build upon one another; therefore, projects are likely to impact some of the same individuals, leading to "double-counting" of impact. For example, a provider may have one project focused on providing primary care services to individuals with serious mental illness and co-occurring medical conditions and another project in which peer providers coach individuals on health and wellness goals. These two projects may serve many of the same individuals, yet their metrics will be reflected separately.

An additional challenge to identifying the client impact is the changes that have occurred through negotiation between HHSC and project leaders. The database initially reflected the number of clients proposed to be served in the initially approved proposal. These estimates were updated following negotiated changes with HHSC; however, the revised impact numbers obtained by HHSC (termed "quantifiable patient impact") sometimes reflected a different metric and unique individuals served could not be similarly updated. The RHPs were also asked to review this variable from the database and made additional changes. These changes may not match the negotiated "quantifiable patient impact" that HHSC collects. Therefore, interested parties should look to the HHSC website at http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml for more current patient impact numbers [Document title: Master Summary Workbooks/ Most Recent Milestones and Metrics for 4-Year Project; Last update: July 9, 2014]. HHSC will continue to update patient impact goals based on ongoing project modifications.

To provide the most interpretable estimate of patient impact, only those projects identifying unique individuals served were used in this analysis. The majority of project proposals (87.1%) identified the number of individuals to be served over the course of the 5-year effort, and these

estimates were captured in client impact. This data includes some missing information, as some proposals identified targets for clients served in later years, but utilized earlier years to establish programs and baseline clients served. Therefore, the projected individuals served are presented for project years 4 and 5, as all projects will be established and reporting on impact in these years. Estimates of individual impact within each region are presented in Table 10.

Table 10. Estimates of Individuals Impacted by RHP Projects

RHP	Total # BH Projects	RHP Projects Reporting Individuals Served (Year 4, Year 5)	Projected Individuals Served in Year 4	Projected Individuals Served in Year 5
1	24	21, 21	5,161	5,836
2	30	28, 28	18,984	26,824
3	46	34, 35	28,119	30,453
4	22	19, 19	4,399	5,912
5	18	15, 15	4,806	6,297
6	35	32, 33	21,862	39,662
7	37	32, 32	22,139	27,912
8	25	23, 23	7,011	10,735
9	21	20, 20	21,877	27,436
10	26	24, 24	16,725	17,861
11	10	5, 5	784	897
12	20	19, 19	5,411	6,868
13	11	9, 9	444	476
14	6	4, 4	593	1,187
15	8	8, 8	6,428	8,015
16	15	11, 11	2,945	3,356
17	8	8, 8	937	1,405
18	16	16, 15	11,439	12,740
19	10	9, 9	615	780
20	7	7, 7	3,850	4,386
All	395	345, 346	184,529	239,038

Since the scope of the projects vary greatly, some projects aim to impact a very large number of individuals (e.g., through quality improvement strategies), while others focus on a very small number of individuals. There were 87 smaller projects (26.7%), focused on serving 200 or fewer individuals over the project period. A similar number fell in the moderate range (*n*=83; 25.5%) with a goal of serving between 201 and 500 individuals during the project period. Ninety projects (27.6%) were moderate to large in size, planning to serve between 501 and 2,000 individuals. The remainder of the projects were considered large (*n*=43; 13.2%), serving between 2,001 and 5,000 consumers, or very large (*n*=23, 7.1%) targeting between 5,001 and 27,000 individuals. Smaller projects tended to focus on specialized programs for a targeted population or more intensive services, while larger projects tended to involve expanding access within large health care systems or the development of system-level changes, such as patient navigation, telemedicine, or data sharing protocols.

Incentive Payments

DSRIP payments are based on successful completion of project goals and milestones, generally split across several specific metrics in each year. The first year of the waiver (Federal Fiscal Year 2011-12) was focused on project submission and approval, and no incentive payments are established for Year 1. The project values for project year 2 (Federal Fiscal Year 2012-13) and project year 3 (Federal Fiscal Year 2013-14) have been approved by CMS. The project values for project years 4 and 5 will not be formally approved until the end of 2014, and the values related to project outcomes are still being finalized. Project valuation represents the maximum of all funds a project may earn if it achieves all of its metrics in a given year.

The median individual project incentive per year for the behavioral health projects were:

- $610,807 in Demonstration Year 2,
- $610,312 in Demonstration Year 3,
- $752,880 in Demonstration Year 4, and
- $719,459 in Demonstration Year 5.

The smallest one-year incentive payment for all projects is $10,254 and the largest proposed one-year incentive payment is $7,538,562. The total projected payments for behavioral health projects across each project year are presented in Table 11. Up to $2,008,049,890 is estimated to support behavioral health Category 1 and Category 2 projects as a result of the 1115 Waiver.

Table 11. Estimates of DSRIP Payments for Behavioral Health Projects

RHP	BH Payments Year 2	Projected BH Payments Year 3	Projected BH Payments Year 4	Projected BH Payments Year 5	Total BH Year 2-5
1	17,052,852	18,346,833	19,113,423	18,118,740	72,631,848
2	21,256,210	22,253,798	23,269,308	21,630,142	88,409,458
3	109,174,355	118,856,864	124,977,077	113,975,648	466,983,943
4	18,620,553	19,434,018	20,149,487	18,225,158	76,429,216
5	22,288,290	24,835,928	27,844,786	29,924531	104,893,535
6	53,921,726	59,522,621	62,346,458	57,987,079	233,777,884
7	51,324,559	53,490,854	57,838,018	53,477,878	216,131,309
8	11,916,940	13,778,476	12,336,942	11,977,166	50,009,524
9	29,497,012	31,270,528	34,353,902	31,501,175	126,622,617
10	55,768,843	58,096,097	61,920,743	56,399,918	232,185,601
11	5,028,692	5,238,320	5,436,989	4,973,392	20,677,393
12	16,073,146	17,290,857	17,863,017	17,183,767	68,410,788
13	2,058,613	2,168,824	2,301,569	2,239,364	8,768,370
14	5,686,903	5,977,848	6,394,834	6,178,657	24,238,242
15	14,260,291	15,074,422	16,529,826	15,295,184	61,159,723
16	8,554,818	9,174,842	9,602,524	8,760,446	36,092,630
17	1,872,799	3,789,988	6,346,059	6,198,879	18,207,725

18	14,953,847	16,445,944	16,864,881	15,314,610	63,579,282
19	2,669,339	2,927,051	3,131,915	3,025,404	11,753,709
20	6,586,488	6,750,948	6,983,542	6,766,116	27,087,094
State	$468,566,276	$504,725,061	$535,605,299	$499,153,254	$2,008,049,890

Quality Improvement Targets

RHPs were required to identify one or more Category 3 outcomes that will be tracked to measure the impact of the projects. These outcomes were selected from a list developed by HHSC and approved by CMS. This list, along with further description of each outcome, can be accessed at http://www.hhsc.state.tx.us/1115-docs/CAT3/Cat3-Brief-Outcomes.xls. In March 2014, following revisions to the Category 3 outcome framework, all RHPs either verified or selected new outcomes measures and these revised outcomes are reflected in the table below. The domains, or categories, for the outcomes chosen in the behavioral health projects are listed in Table 12. The most frequently selected outcomes were in the Behavioral Health/Substance Abuse Care domain (*n*=195, 49.4%), which reflects changes on behavioral health measures. The most common measurement tools utilized are the Patient Health Questionnaire (PHQ) and the Daily Living Activities-20 (DLA-20). The second most frequently selected outcomes were in the Primary Care and Chronic Disease Management domain (*n*=104, 26.3%), with follow-up after psychiatric hospitalization, controlling high blood pressure, depression management screening, and treatment planning representing the most commonly selected outcomes within the domain.

Table 12. Category 3 Outcome Domains

Measure Name	Number of Projects	Percent
Domain 1: Primary Care and Chronic Disease Management	104	26.3%
Domain 2: Potentially Preventable Admissions	5	1.3%
Domain 3: Potentially Preventable Readmissions – 30-day Readmissions	26	6.6%
Domain 6: Patient Satisfaction	48	12.2%
Domain 8: Perinatal and Maternal Child Health	1	0.3%
Domain 9: Right Care, Right Setting	64	16.2%
Domain 10: Quality of Life/Functional Status	76	19.2%
Domain 11: Behavioral Health/Substance Abuse Care	195	49.4%
Domain 14: Healthcare Workforce	5	1.3%
Domain 15: Infectious Disease Management	4	1.0%

Note: Some projects identified more than one Category 3 outcome.

Tables summarizing data for the state and each RHP are presented in Appendix G.

Conclusions

The 1115 Demonstration Waiver has resulted in a wide variety of innovative projects aimed at improving the behavioral health system for Medicaid eligible and low income individuals. There are a variety of providers involved in these behavioral health projects. Although the vast majority of behavioral health projects are being led by local mental health authorities, many of the

projects involve collaborations between community providers and expand access to care in new settings. Discrete regional needs assessments were conducted by each RHP, yet there are many similarities in the local needs identified. This suggests that many communities face similar gaps and barriers to effective behavioral health systems, such as behavioral health workforce shortages, insufficient crisis services, and specific populations without access to care.

Many projects state that they intend to hire additional staff, especially licensed counselors, social workers, and psychiatrists. Given the significant workforce shortages across the state, but particularly in rural areas, this may become a challenge to the success of some projects. Those provider agencies that seek creative strategies to staff projects, such as distance telehealth, partnerships with other community agencies, or hiring newer types of behavioral health staff (e.g., peer specialists or family partners), may have greater success at building capacity. There may also be value in evaluating staff shifts from traditional services to waiver projects to determine if project success compromises the quality or outcomes of existing publicly funded behavioral health services.

Participating providers are required to join in shared learning opportunities within their region, and many proposals discussed plans to attend regular meetings and share goals and achievements. However, there are few structured opportunities for shared learning among similar behavioral health projects across the regions. For example, providers could benefit from opportunities to learn from other providers implementing similar programs or providing services to similar populations. These opportunities could be formal, such as through conferences, meetings, or learning collaboratives, or informal, such as through peer-to-peer networking. The database developed for this project may assist providers in identifying other providers with whom they can share resources and lessons learned. However, state organizations (e.g., state agencies, non-profits, foundations) could also strengthen the efforts through opportunities for formal statewide networking and sharing lessons learned.

Although a subset of the projects approved under the 1115 Demonstration Waiver will be evaluated through the School of Public Health at Texas A&M University, the large number of behavioral health projects offers an opportunity to evaluate the impact of these projects on behavioral health and quality of life outcomes. Core indicators, such as behavioral health penetration rates, utilization of psychiatric hospitals, utilization of emergency departments for psychiatric crises, and rates of homelessness or incarceration for populations with severe mental health or substance use conditions, could be tracked to identify regional differences in outcomes. Additional evaluation could assess effective implementation of evidence-based or promising practices and support the identification of novel programs that could be expanded to other regions. At a minimum, further qualitative information should be gathered to better understand the nature of the projects as they move from planning and installation phases to implementation and maintenance.

The 1115 Demonstration Waiver provides the most significant increase in funding for behavioral health services in Texas in decades. The ability of RHPs to implement projects of their choosing provides insight on regional needs, allows for local innovation, and the testing and development of promising and best practices in the field. It will be critical for the state to demonstrate good return on investment, but the waiver also provides unprecedented opportunities for regional and cross state collaboration, communication, and evaluation to improve the behavioral health of all Texans.

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Appendix A

List of Counties by RHP

RHP 1
1. Anderson
2. Bowie
3. Camp
4. Cass
5. Cherokee
6. Delta
7. Fannin
8. Franklin
9. Freestone
10. Gregg
11. Harrison
12. Henderson
13. Hopkins
14. Houston
15. Hunt
16. Lamar
17. Marion
18. Morris
19. Panola
20. Rains
21. Red River
22. Rusk
23. Smith
24. Titus
25. Trinity
26. Upshur
27. Van Zandt
28. Wood

RHP 2
1. Angelina
2. Brazoria
3. Galveston
4. Hardin
5. Jasper
6. Jefferson
7. Liberty
8. Nacogdoches
9. Newton
10. Orange
11. Polk
12. Sabine
13. San Augustine
14. San Jacinto
15. Shelby
16. Tyler

RHP 3
1. Austin
2. Calhoun
3. Chambers
4. Colorado
5. Fort Bend
6. Harris
7. Matagorda
8. Waller
9. Wharton

RHP 4
1. Aransas
2. Bee
3. Brooks
4. DeWitt
5. Duval
6. Goliad
7. Gonzales
8. Jackson
9. Jim Wells
10. Karnes
11. Kenedy
12. Kleberg
13. Lavaca
14. Live Oak
15. Nueces
16. Refugio
17. San Patricio
18. Victoria

RHP 5
1. Cameron
2. Hidalgo
3. Starr
4. Willacy

RHP 6
1. Atascosa
2. Bandera
3. Bexar
4. Comal
5. Dimmit
6. Edwards
7. Frio
8. Gillespie
9. Guadalupe
10. Kendall
11. Kerr
12. Kinney
13. La Salle
14. McMullen
15. Medina
16. Real
17. Uvalde
18. Val Verde
19. Wilson
20. Zavala

RHP 7
1. Bastrop
2. Caldwell
3. Fayette
4. Hays
5. Lee
6. Travis

RHP 8
1. Bell
2. Blanco
3. Burnet
4. Lampasas
5. Llano
6. Milam
7. Mills
8. San Saba
9. Williamson

RHP 9
1. Dallas
2. Denton
3. Kaufman

RHP 10
1. Ellis
2. Erath
3. Hood
4. Johnson
5. Navarro
6. Parker
7. Somervell
8. Tarrant
9. Wise

RHP 11
1. Brown
2. Callahan
3. Comanche
4. Eastland
5. Fisher
6. Haskell
7. Jones
8. Knox
9. Mitchell
10. Nolan
11. Palo Pinto
12. Shackelford
13. Stephens
14. Stonewall
15. Taylor

RHP 12
1. Armstrong
2. Bailey
3. Borden
4. Briscoe
5. Carson
6. Castro
7. Childress
8. Cochran
9. Collingsworth
10. Cottle
11. Crosby
12. Dallam
13. Dawson
14. Deaf Smith
15. Dickens
16. Donley
17. Floyd
18. Gaines
19. Garza
20. Gray
21. Hale
22. Hall
23. Hansford
24. Hartley
25. Hemphill
26. Hockley
27. Hutchinson
28. Kent
29. King
30. Lamb
31. Lipscomb
32. Lubbock
33. Lynn
34. Moore
35. Motley
36. Ochiltree
37. Oldham
38. Parmer
39. Potter
40. Randall
41. Roberts
42. Scurry
43. Sherman
44. Swisher
45. Terry
46. Wheeler
47. Yoakum

RHP 13
1. Coke
2. Coleman
3. Concho
4. Crockett
5. Irion
6. Kimble
7. Mason
8. McCulloch
9. Menard
10. Pecos
11. Reagan
12. Runnels
13. Schleicher
14. Sterling
15. Sutton
16. Terrell
17. Tom Green

RHP 14
1. Andrews
2. Brewster
3. Crane
4. Culberson
5. Ector
6. Glasscock
7. Howard
8. Jeff Davis
9. Loving
10. Martin
11. Midland
12. Presidio
13. Reeves
14. Upton
15. Ward
16. Winkler

RHP 15
1. El Paso
2. Hudspeth

RHP 16
1. Bosque
2. Coryell
3. Falls
4. Hamilton
5. Hill
6. Limestone
7. McLennan

RHP 17
1. Brazos
2. Burleson
3. Grimes
4. Leon
5. Madison
6. Montgomery
7. Robertson
8. Walker
9. Washington

RHP 18
1. Collin
2. Grayson
3. Rockwall

RHP 19
1. Archer
2. Baylor
3. Clay
4. Cooke
5. Foard
6. Hardeman
7. Jack
8. Montague
9. Throckmorton
10. Wichita
11. Wilbarger
12. Young

RHP 20
1. Jim Hogg
2. Maverick
3. Webb
4. Zapata

Appendix B

Variables Reviewed by RHPs

The following variables from the Behavioral Health Waiver Projects Database were sent to the Anchor contacts within each RHP for review and editing:

- RHP Unique Project ID
- Provider Name
- Option Number
- Brief Project Description
- Counties Served
- Estimated Client Impact (Years 2-5)
- Age Groups Targeted
- Population of Focus
- Integrated Mental Health and Substance Abuse – Quadrants in which Care is provided (MH/SA Quadrant Model)
- Integrated Physical Health and Behavioral Health – Quadrants in which Care is Provided (BH/PH Quadrant Model)
- Best Practices Implemented (Fidelity Monitoring)
- Technology Development/Use
- Crisis Services Provided

Appendix C

Evidence-Based or Promising Behavioral Health Practices

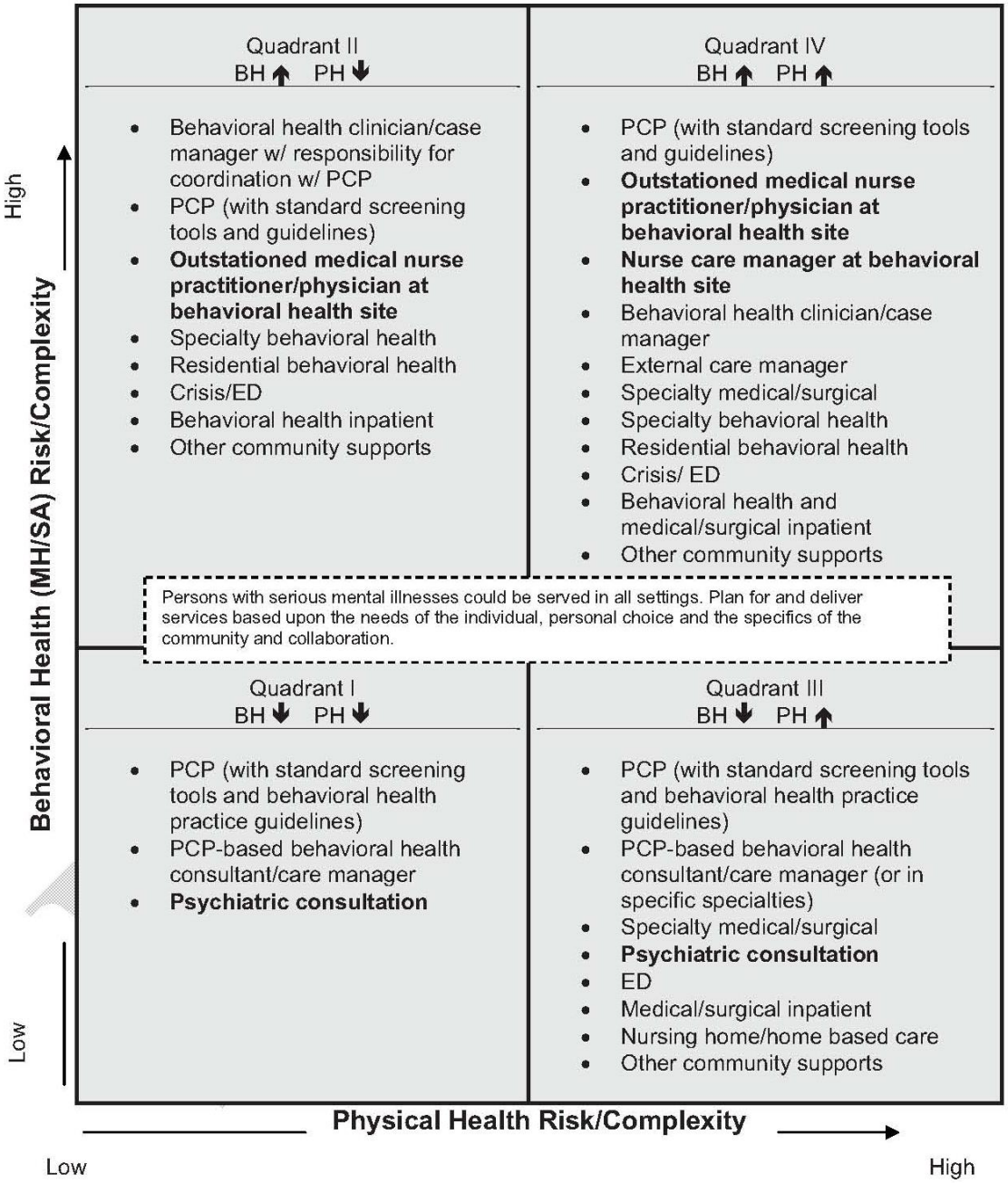
The table includes the specific evidence-based or promising practices that the RHP proposals included as a project intervention. The number of proposals reflects those that clearly identified use of the practice. The (Unclear) presents the number of proposals in which something resembling the practice was mentioned but it was not described in such a way that reviewers were confident it would actually be implemented as a project intervention.

Number of Proposals (Unclear)	Best Practices
30 (6)	Cognitive Behavioral Therapy (CBT)
23 (4)	Assertive Community Treatment (ACT)
16 (8)	Cognitive Processing Therapy (CPT)
15 (8)	Recovery Supports
14 (6)	Supported Employment
14 (7)	Whole Health and Resilience (WHR)
13	Applied Behavior Analysis (ABA)
12 (4)	Seeking Safety
12 (5)	Motivational Interviewing (MI)
12 (7)	Integrated Dual Diagnosis Treatment (IDDT)
11 (5)	Wellness Recovery Action Planning (WRAP)
9 (4)	Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)
7 (5)	Wraparound Planning
6 (6)	Whole Health Action Management (WHAM)
6	Illness Management and Recovery (IMR)
6	Chronic Care Model
5 (4)	Screening, Brief Intervention, and Referral to Treatment (SBIRT)
5	Individualized Self Health Action Planning for Empowerment (In SHAPE)
5 (5)	Collaborative Care
4	Cognitive Adaptive Training (CAT)
4	Aggression Replacement Therapy (ART)
3 (5)	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
3	Nurturing Parenting
3	Cognitive Enhancement Therapy (CET)
3 (5)	Dialectical Behavior Therapy (DBT)
3 (4)	The Matrix Model
2	Medication Algorithms (STAR*D, TMAP)
2	Diabetes Empowerment Education Program (DEEP)
2	Family Psychoeducation
2	Systemic, Therapeutic, Assessment, Respite and Treatment (START)
1 (4)	Parent Child Interaction Therapy (PCIT)
1 (4)	Multi-Systemic Therapy (MST)
1 (4)	Motivational Enhancement Therapy (MET)

1	Electroconvulsive Therapy (ECT)
1	Georgia Real Choice Systems Change Model
1	Brazelton Touchpoints
1	Frequent Users Systems Engagement (FUSE)
1	Functional Family Therapy (FFT)
1	Hazelden
1	Moral Reconation Therapy
1	Barkley's Defiant Child
1	Skills Streaming
1	Bringing Everyone into the Zone (BEITZ)
1	Operation Resilient Families
1	Trauma Recovery and Empowerment (TREM)
1	Mental Health First Aid
1	Healthy Eating Active Living (HEAL)
1	Service Outreach and Recovery (SOAR)
1	12 Steps
1	Care Transitions Intervention
1	Critical Time Intervention
0 (5)	Multidimensional Treatment Foster Care (MTFC)

Appendix D

The Four Quadrant Clinical Integration Model



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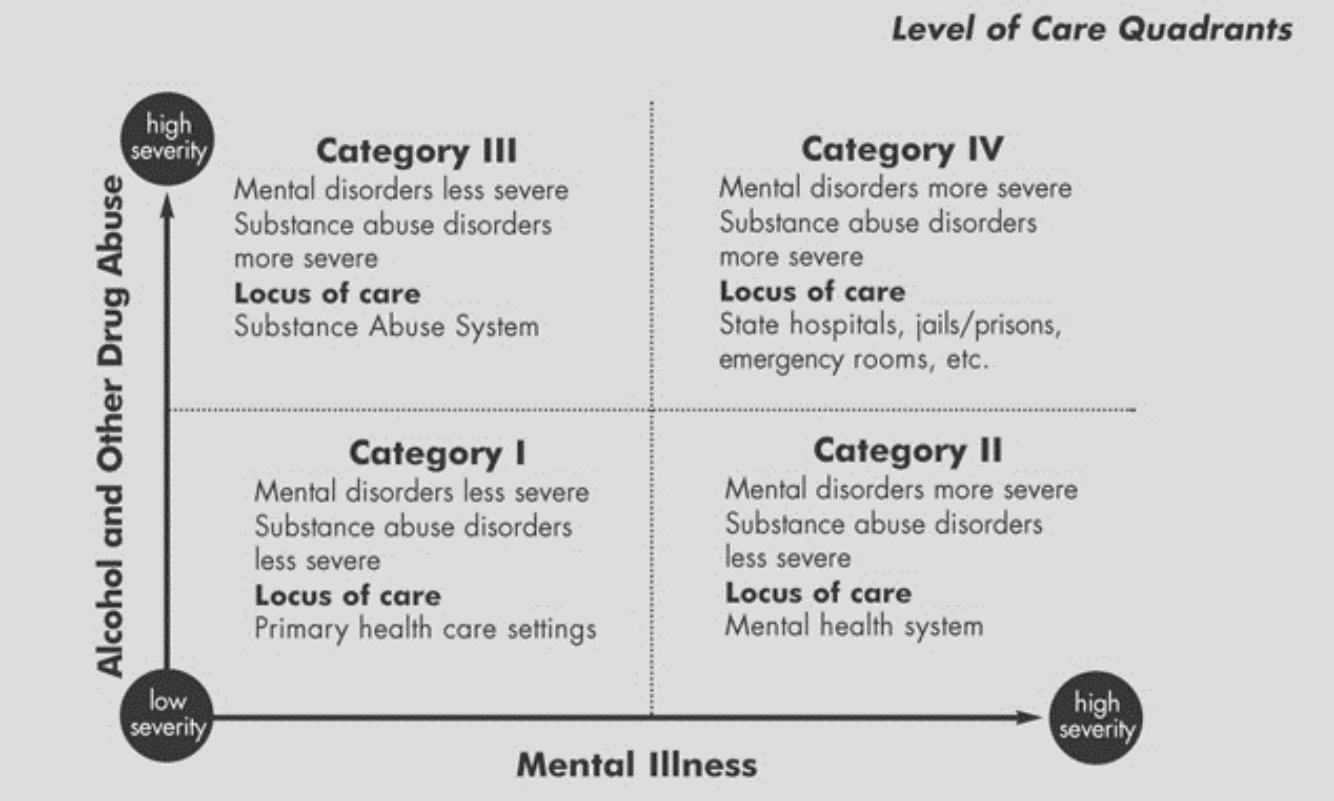
Appendix E

The quadrants of care for co-occurring substance use and mental health disorders:



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Appendix F

Acronyms Used in the Report

BH – Behavioral health

CMS – Center for Medicare and Medicaid Services

DEEP – Diabetes Empowerment Education Program

DSRIP – Delivery System Reform Incentive Payment

FQHC – Federally Qualified Health Center

HHSC – Texas Health and Human Services Commission

IDD – Intellectual and Developmental Disabilities

IMPACT - Improving Mood-Promoting Access to Collaborative Treatment

In SHAPE - Individualized Self Health Action Planning for Empowerment

LMHA – Local Mental Health Authority

LCSW – Licensed Clinical Social Worker

LMSW – Licensed Master Social Worker

LPC – Licensed Professional Counselor

MH – Mental health

RHP – Regional healthcare partnership

SA – Substance abuse

SBIRT – Screening, Brief Intervention, and Referral to Treatment

SED – Serious emotional disturbance

SMI – Severe mental illness

TIEMH – Texas Institute for Excellence in Mental Health

Appendix G
1115 Waiver Behavioral Health Projects
Summary Tables

1115 Waiver Behavioral Health Projects – Summary Tables

Statewide Summary	Number of Projects	Total Individuals Served (Year 4)	Potential Incentive Payment (Year 4)	Total Individuals Served (Years 4-5)	Potential Incentive Payment (Years 2-5)
Total Across All Category 1 & 2 Projects	395	184,529[1]	$535,605,299	423,567[2]	$2,008,049,890
Projects Focused Across the Age Span	126	77,902[3]	$156,583,429	177,843[3]	$586,731,696
Projects Focused on Children Only	34	9,184[4]	$40,965,283	20,030[5]	$153,956,305
Projects Focused on Adults Only	235	97,443[6]	$338,056,587	225,694[7]	$1,267,361,889
Projects Focused on Mental Health**	238	119,472[8]	$337,931,670	267,943[8]	$1,267,521,178
Projects Focused on Substance Use Disorders**	63	44,681[9]	$80,488,891	97,012[9]	$301,921,682
Projects Focused on IDD**	14	2,163[10]	$10,494,516	4,997[10]	$40,388,407
Projects Focused on Co-occurring BH/PH	139	90,471[11]	$202,213,305	214,670[11]	$761,126,965
Projects focused on Co-occurring MH/SA	82	53,562[12]	$133,406,531	117,312[12]	$497,988,134
Projects Focused on Co-occurring IDD/BH	33	3,607[13]	$39,854,022	8,309[13]	$148,906,089
Projects Enhancing Crisis Services	113	58,711[14]	$172,036,392	125,484[14]	$636,261,490
Projects Enhancing or Using Telehealth	85	34,889[15]	$100,507,509	79,901[15]	$380,983,351
Projects Enhancing Electronic Health Records	39	20,802[16]	$50,669,164	48,223[16]	$194,060,846
Projects Using Evidence-based/Promising Practices	173	66,139[17]	$240,926,545	147,682[18]	$901,879,094

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.

[1] Information provided on 345 projects. [2] Information provided on 346 projects. [3] Information provided on 106 projects. [4] Information provided on 30 projects. [5] Information provided on 29 projects. [6] Information provided on 208 projects. [7] Information provided on 210 projects. [8] Information provided on 201 projects. [9] Information provided on 59 projects. [10] Information provided on 12 projects. [11] Information provided on 129 projects. [12] Information provided on 79 projects. [13] Information provided on 31 projects. [14] Information provided on 97 projects. [15] Information provided on 64 projects. [16] Information provided on 38 projects. [17] Information provided on 163 projects.[18] Information provided on 164 projects.

* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.

** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

Disclaimers: This data reflects a review of approved project proposals and so may not reflect the current status of 1115 projects. The table summarizes a variety of project characteristics; therefore, individual projects may be represented in multiple categories. Total number of individuals served is provided for the final two years of the project, when impact numbers are required to be tracked; however, projects may plan to serve individuals in earlier years. Total number of individuals served may be provided for a subset of proposals in which this information was provided in the proposal. Individuals may be served across multiple projects; therefore," total individuals served" does not reflect unique individuals. In addition, estimated individuals to be served may not represent the most currently approved impact numbers. Potential incentive payments for project years 2 and 3 have been updated to reflect CMS-approved incentive payments; however, incentives for FFY15-16 are still to be finalized. Project valuation reflects the maximum of all funds a Category 1 or 2 project may earn if it achieves all metric targets.

1115 Waiver Behavioral Health Projects – Summary Tables

RHP 1 Summary	Number of Projects	Total Individuals Served (Year 4)	Potential Incentive Payment (Year 4)	Total Individuals Served (Years 4-5)	Potential Incentive Payment (Years 2-5)
Total Across All Category 1 & 2 Projects	24	5,161[1]	$19,113,423	10,997[1]	$72,631,848
Projects Focused Across the Age Span	5	195[2]	$1,880,555	463[2]	$8,447,365
Projects Focused on Children Only	0	N/A	N/A	N/A	N/A
Projects Focused on Adults Only	19	4,966	$17,232,868	10,534	$64,184,483
Projects Focused on Mental Health**	19	4,220[3]	$17,532,279	8,936[3]	$66,110,011
Projects Focused on Substance Use Disorders**	10	2,017[4]	$6,553,703	4,167[4]	$26,900,149
Projects Focused on IDD**	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	9	2,474[4]	$9,813,751	5,336[4]	$37,330,776
Projects focused on Co-occurring MH/SA	9	3,075	$10,020,757	6,414	$38,068,541
Projects Focused on Co-occurring IDD/BH	0	N/A	N/A	N/A	N/A
Projects Enhancing Crisis Services	6	2,714	$8,115,461	5,578	$31,475,606
Projects Enhancing or Using Telehealth	5	2,322[5]	$7,344,267	4,814[5]	$ 29,955,721
Projects Enhancing Electronic Health Records	4	670	$1,295,586	1,525	$5,478,427
Projects Using Evidence-based/Promising Practices	8	900	$2,937,812	1,961	$10,498,442

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 21 projects. [2] Information provided on 2 projects. [3] Information provided on 16 projects. [4] Information provided on 8 projects. [5] Information provided on 4 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 2 Summary	Number of Projects	Total Individuals Served (Year 4)	Potential Incentive Payment (Year 4)	Total Individuals Served (Years 4-5)	Potential Incentive Payment (Years 2-5)
Total Across All Category 1 & 2 Projects	30	18,984[1]	$23,269,308	45,808[1]	$88,409,458
Projects Focused Across the Age Span	5	14,742	$9,825,107	34,574	$37,844,429
Projects Focused on Children Only	3	130	$1,308,893	285	$4,985,974
Projects Focused on Adults Only	22	4,112[2]	$12,135,308	10,949[2]	$45,579,055
Projects Focused on Mental Health**	19	5,334[3]	$15,709,075	14,768[3]	$59,397,640
Projects Focused on Substance Use Disorders**	6	1,837	$5,033,728	3,919	$19,282,157
Projects Focused on IDD**	2	135	$642,269	320	$2,435,971
Projects Focused on Co-occurring BH/PH	9	14,232[4]	$7,555,054	32,140[4]	$29,143,669
Projects focused on Co-occurring MH/SA	7	2,422	$5,789,982	5,444	$22,219,004
Projects Focused on Co-occurring IDD/BH	2	28	$597,336	65	$2,278,573
Projects Enhancing Crisis Services	9	1,765	$5,229,199	3,794	$20,101,411
Projects Enhancing or Using Telehealth	7	3,992[5]	$9,022,512	11,709[5]	$34,139,464
Projects Enhancing Electronic Health Records	4	2,209	$4,954,588	5,291	$19,411,113
Projects Using Evidence-based/Promising Practices	13	2,692[6]	$8,366,125	6,169[6]	$31,978,405

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.

[1] Information provided on 28 projects. [2] Information provided on 20 projects. [3] Information provided on 17 projects. [4] Information provided on 8 projects.
[5] Information provided on 6 projects. [6] Information provided on 12 projects.

* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.

** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

Disclaimers: This data reflects a review of approved project proposals and so may not reflect the current status of 1115 projects. The table summarizes a variety of project characteristics; therefore, individual projects may be represented in multiple categories. Total number of individuals served is provided for the final two years of the project, when impact numbers are required to be tracked; however, projects may plan to serve individuals in earlier years. Total number of individuals served may be provided for a subset of proposals in which this information was provided in the proposal. Individuals may be served across multiple projects; therefore," total individuals served" does not reflect unique individuals. In addition, estimated individuals to be served may not represent the most currently approved impact numbers. Potential incentive payments for project years 2 and 3 have been updated to reflect CMS-approved incentive payments; however, incentives for FFY15-16 are still to be finalized. Project valuation reflects the maximum of all funds a Category 1 or 2 project may earn if it achieves all metric targets.

1115 Waiver Behavioral Health Projects – Summary Tables

RHP 3 Summary	Number of Projects	Total Individuals Served (Year 4)	Potential Incentive Payment (Year 4)	Total Individuals Served (Years 4-5)	Potential Incentive Payment (Years 2-5)
Total Across All Category 1 & 2 Projects	46	28,119[1]	$124,977,077	58,572[2]	$466,983,943
Projects Focused Across the Age Span	3	3020[2]	$9,241,108	6,300[2]	$32,808,754
Projects Focused on Children Only	7	382[3]	$17,440,125	821[3]	$66,298,936
Projects Focused on Adults Only	39	24,717[4]	$98,295,844	51,451[5]	$367,876,253
Projects Focused on Mental Health**	36	18,783[6]	$90,719,167	39,081[7]	$337,396,045
Projects Focused on Substance Use Disorders**	5	9,300[8]	$12,789,709	18,880[8]	$45,945,237
Projects Focused on IDD**	4	104[2]	$6,031,893	218[2]	$23,411,794
Projects Focused on Co-occurring BH/PH	15	9,766[9]	$35,926,397	20,518[9]	$133,355,607
Projects focused on Co-occurring MH/SA	6	7,714[10]	$17,968,720	15,803[10]	$65,819,427
Projects Focused on Co-occurring IDD/BH	6	952[10]	$7,887,310	2,017[10]	$30,105,369
Projects Enhancing Crisis Services	13	13,139[9]	$34,021,919	26,872[9]	$124,930,836
Projects Enhancing or Using Telehealth	1	2,520	$4,277,532	5,250	$14,178,531
Projects Enhancing Electronic Health Records	9	750[2]	$2,147,330	1,600[2]	$8,489,422
Projects Using Evidence-based/Promising Practices	25	13,248[11]	$65,235,610	27,749[11]	$246,427,969

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided for 34 projects. [2] Information provided for 2 projects. [3] Information provided on 3 projects. [4] Information provided on 29 projects. [5] Information provided on 30 projects. [6] Information provided on 22 projects. [7] Information provided on 23 projects. [8] Information provided on 4 projects. [9] Information provided on 11 projects. [10] Information provided on 5 projects. [11] Information provided on 21 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 4 Summary	Number of Projects	Total Individuals Served (Year 4)	Potential Incentive Payment (Year 4)	Total Individuals Served (Years 4-5)	Potential Incentive Payment (Years 2-5)
Total Across All Category 1 & 2 Projects	22	4,399[1]	$20,149,487	10,311	$76,429,216
Projects Focused Across the Age Span	8	501[2]	$3,296,711	1,299[2]	$12,548,527
Projects Focused on Children Only	1	132	$1,180,298	330	$4,324,839
Projects Focused on Adults Only	13	3,766[3]	$15,672,478	8,682[3]	$59,555,850
Projects Focused on Mental Health**	8	977	$5,960,708	2,585	$22,057,768
Projects Focused on Substance Use Disorders**	4	595	$4,072,888	1,525	$14,919,977
Projects Focused on IDD**	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	14	3,787[4]	$12,622,881	8,730[4]	$48,491,241
Projects focused on Co-occurring MH/SA	5	2,470	$7,977,425	5,751	$30,336,675
Projects Focused on Co-occurring IDD/BH	1	25	$774,390	55	$2,372,665
Projects Enhancing Crisis Services	5	305[5]	$4,910,154	726[5]	$17,548,960
Projects Enhancing or Using Telehealth	3	282[6]	$3,694,334	780[6]	$13,848,180
Projects Enhancing Electronic Health Records	4	2,238	$6,362,033	5,108	$24,210,560
Projects Using Evidence-based/Promising Practices	7	1,386	$4,397,739	3,141	$16,329,456

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 19 projects. [2] Information provided on 7 projects. [3] Information provided on 11 projects. [4] Information provided on 13 projects. [5] Information provided on 4 projects. [6] Information provided on 2 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

Disclaimers: This data reflects a review of approved project proposals and so may not reflect the current status of 1115 projects. The table summarizes a variety of project characteristics; therefore, individual projects may be represented in multiple categories. Total number of individuals served is provided for the final two years of the project, when impact numbers are required to be tracked; however, projects may plan to serve individuals in earlier years. Total number of individuals served may be provided for a subset of proposals in which this information was provided in the proposal. Individuals may be served across multiple projects; therefore," total individuals served" does not reflect unique individuals. In addition, estimated individuals to be served may not represent the most currently approved impact numbers. Potential incentive payments for project years 2 and 3 have been updated to reflect CMS-approved incentive payments; however, incentives for FFY15-16 are still to be finalized. Project valuation reflects the maximum of all funds a Category 1 or 2 project may earn if it achieves all metric targets.

1115 Waiver Behavioral Health Projects – Summary Tables

RHP 5 Summary	Number of Projects	Total Individuals Served (Year 4)	Potential Incentive Payment (Year 4)	Total Individuals Served (Years 4-5)	Potential Incentive Payment (Years 2-5)
Total Across All Category 1 & 2 Projects	18	4,806[1]	$27,844,786	11,103[1]	$104,893,535
Projects Focused Across the Age Span	13	3,660[2]	$18,740,153	8302[2]	$71,992,460
Projects Focused on Children Only	1	90	$1,521,000	180	$5,070,000
Projects Focused on Adults Only	4	1,056	$7,583,633	2621	$27,831,075
Projects Focused on Mental Health**	7	1,947[3]	$10,554,128	4,608[3]	$41,367,061
Projects Focused on Substance Use Disorders**	1	310	$268,657	830	$1,056,218
Projects Focused on IDD**	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	11	2,626[2]	$19,515,825	6,109[2]	$72,406,340
Projects focused on Co-occurring MH/SA	9	2,847[4]	$17,417,143	6,691[4]	$66,088,843
Projects Focused on Co-occurring IDD/BH	1	138	$799,362	284	$2,444,817
Projects Enhancing Crisis Services	10	1,860[5]	$9,567,726	4,452[5]	$38,948,116
Projects Enhancing or Using Telehealth	9	1,854[5]	$6,799,410	4,451[5]	$28,097,898
Projects Enhancing Electronic Health Records	7	2,673[6]	$16,584,806	6,326[6]	$63,537,538
Projects Using Evidence-based/Promising Practices	9	2,530[4]	$18,468,850	5,908[4]	$68,750,852

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided for 15 projects. [2] Information provided on 10 projects. [3] Information provided on 5 projects. [4] Information provided on 8 projects. [5] Information provided on 7 projects. [6] Information provided on 6 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 6 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	35	21,862[1]	$62,346,458	61,524[2]	$233,777,884
Projects Focused Across the Age Span	6	4,963[3]	$6,238,709	13,999[3]	$23,980,164
Projects Focused on Children Only	5	1,731	$7,257,349	3,641	$27,219,525
Projects Focused on Adults Only	24	15,168[4]	$48,850,400	43,884[5]	$182,578,195
Projects Focused on Mental Health*	18	16,379	$30,937,463	38,291	$115,502,664
Projects Focused on Substance Use Disorders*	4	2,850	$5,028,561	7,100	$18,863,563
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	11	9,324[6]	$21,829,313	34,189	$81,751,502
Projects focused on Co-occurring MH/SA	11	8,040	$19,100,877	17,208	$72,098,023
Projects Focused on Co-occurring IDD/BH	2	179	$4,010,885	496	$15,039,412
Projects Enhancing Crisis Services	13	9,973[7]	$24,330,185	21,208[7]	$90,491,151
Projects Enhancing or Using Telehealth	5	939	$7,616,663	2,256	$28,692,752
Projects Enhancing Electronic Health Records	1	1,200	$1,433,650	2,400	$5,379,368
Projects Using Evidence-based/Promising Practices**	18	9,546	$24,616,099	25,061	$93,285,882

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 32 projects. [2] Information provided on 33 projects. [3] Information provided on 5 projects. [4] Information provided on 22 projects. [5] Information provided on 23 projects. [6] Information provided on 10 projects. [7] Information provided on 12 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 7 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	37	22,139[1]	$57,838,018	50,051[1]	$216,131,309
Projects Focused Across the Age Span	8	14,054	$22,781,678	31,909	$84,317,472
Projects Focused on Children Only	6	1,792	$4,022,613	4,197	$15,268,717
Projects Focused on Adults Only	23	6,293[2]	$31,033,727	13,945[2]	$116,545,120
Projects Focused on Mental Health*	21	16,404[3]	$34,084,324	37,492[3]	$127,367,902
Projects Focused on Substance Use Disorders*	5	6,303	$9,297,463	14,060	$35,829,754
Projects Focused on IDD*	2	60	$802,635	165	$3,132,409
Projects Focused on Co-occurring BH/PH	15	17,325	$31,500,625	39,149	$118,448,526
Projects focused on Co-occurring MH/SA	8	8,237	$17,564,481	19,013	$63,974,131
Projects Focused on Co-occurring IDD/BH	3	60[4]	$1,952,785	165[4]	$7,448,027
Projects Enhancing Crisis Services	11	4,627[5]	$26,369,014	9,673[5]	$95,141,856
Projects Enhancing or Using Telehealth	6	4,753[6]	$10,789,014	10,593[6]	$40,070,973
Projects Enhancing Electronic Health Records	2	810	$1,420,611	1,910	$5,637,909
Projects Using Evidence-based/Promising Practices**	21	12,346	$31,589,595	28,131	$116,329,875

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 32 projects. [2] Information provided on 18 projects. [3] Information provided on 19 projects. [4] Information provided on 2 projects. [5] Information provided on 7 projects. [6] Information provided on 5 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 8 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	25	7,011[1]	$12,336,942	17,746[1]	$50,009,524
Projects Focused Across the Age Span	6	4,338	$1,691,351	11,673	$7,938,555
Projects Focused on Children Only	2	156	$1,030,113	346	$3,897,209
Projects Focused on Adults Only	17	2,517[2]	$9,615,478	5,727[2]	$38,173,760
Projects Focused on Mental Health*	15	6,042[3]	$8,000,867	15,176[3]	$33,697,257
Projects Focused on Substance Use Disorders*	2	1,850	$911,469	4,550	$3,366,094
Projects Focused on IDD*	3	1,544	$1,335,409	3,618	$5,078,610
Projects Focused on Co-occurring BH/PH	5	1,608	$1,157,181	3,598	$4,552,682
Projects focused on Co-occurring MH/SA	3	368	$664,471	1,091	$2,603,574
Projects Focused on Co-occurring IDD/BH	2	44	$940,992	118	$3,732,172
Projects Enhancing Crisis Services	5	1,136	$4,952,703	2,616	$19,701,954
Projects Enhancing or Using Telehealth	7	2,150[4]	$4,443,010	5,025[4]	$17,400,430
Projects Enhancing Electronic Health Records	5	3,808	$1,712,277	10,198	$7,958,498
Projects Using Evidence-based/Promising Practices**	11	1,498	$3,848,247	3,628	$15,020,464

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 23 projects. [2] Information provided on 15 projects. [3] Information provided on 13 projects. [4] Information provided on 5 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

Disclaimers: This data reflects a review of approved project proposals and so may not reflect the current status of 1115 projects. The table summarizes a variety of project characteristics; therefore, individual projects may be represented in multiple categories. Total number of individuals served is provided for the final two years of the project, when impact numbers are required to be tracked; however, projects may plan to serve individuals in earlier years. Total number of individuals served may be provided for a subset of proposals in which this information was provided in the proposal. Individuals may be served across multiple projects; therefore," total individuals served" does not reflect unique individuals. In addition, estimated individuals to be served may not represent the most currently approved impact numbers. Potential incentive payments for project years 2 and 3 have been updated to reflect CMS-approved incentive payments; however, incentives for FFY15-16 are still to be finalized. Project valuation reflects the maximum of all funds a Category 1 or 2 project may earn if it achieves all metric targets.

1115 Waiver Behavioral Health Projects – Summary Tables

RHP 9 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	21	21,877[1]	$34,353,902	49,313[1]	$126,622,617
Projects Focused Across the Age Span	7	2,565	$9,020,595	6,099	$32,041,494
Projects Focused on Children Only	3	3,297	$4,728,673	7,496	$17,595,064
Projects Focused on Adults Only	11	16,015[2]	$20,604,634	35,718[2]	$76,986,059
Projects Focused on Mental Health*	11	13,329[2]	$20,238,649	29,699[2]	$77,145,826
Projects Focused on Substance Use Disorders*	5	5,609	$4,167,685	11,769	$15,577,682
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	10	14,858	$17,355,974	33,146	$64,957,425
Projects focused on Co-occurring MH/SA	2	3250	$6,355,417	7,750	$23,806,375
Projects Focused on Co-occurring IDD/BH	5	579	$4,162,193	1,547	$15,311,041
Projects Enhancing Crisis Services	8	8,708[3]	$14,602,276	18,835[3]	$52,234,856
Projects Enhancing or Using Telehealth	4	8,219	$7,841,799	18,102	$29,461,834
Projects Enhancing Electronic Health Records	4	2,981	$4,801,164	6,496	$18,189,740
Projects Using Evidence-based/Promising Practices**	8	2,161	$7,033,519	4,519	$25,775,972

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 20 projects. [2] Information provided on 10 projects. [3] Information provided on 7 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 10 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	26	16,725[1]	$61,920,743	34,586[1]	$232,185,601
Projects Focused Across the Age Span	15	10,287[2]	$33,764,683	21,095[2]	$125,822,831
Projects Focused on Children Only	1	300	$262,500	630	$1,057,500
Projects Focused on Adults Only	10	6,138	$27,893,560	12,861	$105,305,270
Projects Focused on Mental Health*	15	9,599[2]	$37,147,713	19,112[2]	$138,347,201
Projects Focused on Substance Use Disorders*	5	4,932	$12,326,580	10,146	$46,399,580
Projects Focused on IDD*	1	78	$469,334	180	$1,782,072
Projects Focused on Co-occurring BH/PH	9	5,307[3]	$20,564,447	11,335[3]	$76,067,618
Projects focused on Co-occurring MH/SA	6	5,773	$14,149,954	12,452	$53,499,990
Projects Focused on Co-occurring IDD/BH	4	708	$10,599,129	1,490	$40,236,095
Projects Enhancing Crisis Services	3	1,950	$6,358,782	4,550	$24,056,461
Projects Enhancing or Using Telehealth	7	1,738[4]	$19,359,620	3,556[4]	$71,949,206
Projects Enhancing Electronic Health Records	2	1,865	$4,851,891	3,738	$17,870,294
Projects Using Evidence-based/Promising Practices**	16	12,467[5]	$47,027,044	25,099[5]	$175,873,590

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 24 projects. [2] Information provided on 13 projects. [3] Information provided on 8 projects. [4] Information provided on 6 projects. [5] Information presented on 15 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 11 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	10	784[1]	$5,436,989	1,681[1]	$20,677,393
Projects Focused Across the Age Span	7	784[1]	$4,603,444	1,681[1]	$17,391,710
Projects Focused on Children Only	0	N/A	N/A	N/A	N/A
Projects Focused on Adults Only	3	Missing	$833,545	Missing	$3,285,683
Projects Focused on Mental Health*	9	745[2]	$5,342,354	1,602[2]	$20,320,982
Projects Focused on Substance Use Disorders*	1	39	$94,635	79	$356,411
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	0	N/A	N/A	N/A	N/A
Projects focused on Co-occurring MH/SA	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring IDD/BH	0	N/A	N/A	N/A	N/A
Projects Enhancing Crisis Services	3	695[3]	$2,593,681	1,416[3]	$9,777,866
Projects Enhancing or Using Telehealth	5	15[4]	$2,474,401	31[4]	$9,513,998
Projects Enhancing Electronic Health Records	0	N/A	N/A	N/A	N/A
Projects Using Evidence-based/Promising Practices**	1	Missing	$454,346	Missing	$1,715,238

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 5 projects. [2] Information provided on 4 projects. [3] Information provided on 2 projects. [4] Information provided on 1 project.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 12 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	20	5,411[1]	$17,863,017	12,279[1]	$68,410,788
Projects Focused Across the Age Span	10	1,461[2]	$3,726,345	3,203[2]	$16,059,253
Projects Focused on Children Only	1	50	$444,677	105	$1,710,068
Projects Focused on Adults Only	9	3,900	$13,691,995	8,971	$50,641,467
Projects Focused on Mental Health*	12	4,454[3]	$12,839,491	10,159[3]	$47,275,876
Projects Focused on Substance Use Disorders*	3	934	$4,494,915	2,034	$15,851,243
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	7	953	$5,404,386	2,256	$22,533,161
Projects focused on Co-occurring MH/SA	3	1,745	$5,946,734	3,720	$21,297,666
Projects Focused on Co-occurring IDD/BH	0	N/A	N/A	N/A	N/A
Projects Enhancing Crisis Services	5	1,012[4]	$5,139,047	2,079[4]	$19,358,097
Projects Enhancing or Using Telehealth	4	67[5]	$768,311	210[5]	$2,933,355
Projects Enhancing Electronic Health Records	1	770	$4,061,384	1,705	$14,178,069
Projects Using Evidence-based/Promising Practices**	5	2,120	$6,918,448	4,545	$25,017,158

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 19 projects. [2] Information provided on 9 projects. [3] Information provided on 11 projects. [4] Information provided on 4 projects. [5] Information provided on 3 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 13 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	11	444[1]	$2,301,569	920[1]	$8,768,370
Projects Focused Across the Age Span	4	219[2]	$890,490	460[2]	$3,236,863
Projects Focused on Children Only	0	N/A	N/A	N/A	N/A
Projects Focused on Adults Only	7	225[3]	$1,411,079	460[3]	$5,531,507
Projects Focused on Mental Health*	7	223[4]	$1,101,146	518[4]	$4,368,772
Projects Focused on Substance Use Disorders*	0	N/A	N/A	N/A	N/A
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	2	93	$520,140	143	$1,960,815
Projects focused on Co-occurring MH/SA	2	14	$144,326	35	$583,603
Projects Focused on Co-occurring IDD/BH	1	122	$627,069	243	$2,219,087
Projects Enhancing Crisis Services	2	211	$675,679	441	$2,403,268
Projects Enhancing or Using Telehealth	2	Missing	$300,074	Missing	$1,144,481
Projects Enhancing Electronic Health Records	0	N/A	N/A	N/A	N/A
Projects Using Evidence-based/Promising Practices**	5	135	$660,706	316	$2,721,247

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 9 projects. [2] Information provided on 3 projects. [3] Information provided on 6 projects. [4] Information provided on 5 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 14 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	6	593[1]	$6,394,834	1,780[1]	$24,238,242
Projects Focused Across the Age Span	3	72[2]	$1,981,888	216[2]	$7,482,043
Projects Focused on Children Only	0	N/A	N/A	N/A	N/A
Projects Focused on Adults Only	3	521	$4,412,946	1,564	$16,756,199
Projects Focused on Mental Health*	3	161[2]	$2,651,387	484[2]	$9,787,083
Projects Focused on Substance Use Disorders*	2	120[2]	$2,096,840	360[2]	$7,511,590
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	2	312	$2,577,095	936	$10,430,967
Projects focused on Co-occurring MH/SA	1	120	$1,166,352	360	$4,020,192
Projects Focused on Co-occurring IDD/BH	0	N/A	N/A	N/A	N/A
Projects Enhancing Crisis Services	0	N/A	N/A	N/A	N/A
Projects Enhancing or Using Telehealth	3	161[2]	$2,651,387	484[2]	$9,787,083
Projects Enhancing Electronic Health Records	0	N/A	N/A	N/A	N/A
Projects Using Evidence-based/Promising Practices**	2	120[2]	$2,096,840	360[2]	$7,511,590

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 4 projects. [2] Information provided on 1 project.
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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 15 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	8	6,428	$16,529,826	14,443	$61,159,723
Projects Focused Across the Age Span	4	3,875	$6,572,462	8,715	$24,403,929
Projects Focused on Children Only	2	624	$459,150	1,349	$1,712,625
Projects Focused on Adults Only	2	1,929	$9,498,214	4,379	$35,043,169
Projects Focused on Mental Health*	7	6,228	$15,571,204	14,043	$57,577,968
Projects Focused on Substance Use Disorders*	1	300	$791,220	800	$2,799,238
Projects Focused on IDD*	1	200	$958,622	400	$3,581,755
Projects Focused on Co-occurring BH/PH	1	2,700	$2,599,607	5,940	$9,715,165
Projects focused on Co-occurring MH/SA	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring IDD/BH	1	200	$958,622	400	$3,581,755
Projects Enhancing Crisis Services	4	4,829	$13,056,443	10,719	$48,340,089
Projects Enhancing or Using Telehealth	1	675	$2,223,013	1,575	$8,307,771
Projects Enhancing Electronic Health Records	0	N/A	N/A	N/A	N/A
Projects Using Evidence-based/Promising Practices**	2	224	$1,187,536	449	$4,430,461

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 16 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	15	2,945[1]	$9,602,524	6,301[1]	$36,092,630
Projects Focused Across the Age Span	5	1,165[2]	$4,583,821	2,371[2]	$16,833,621
Projects Focused on Children Only	1	125	$331,668	275	$1,110,075
Projects Focused on Adults Only	9	1,655[3]	$4,687,035	3,665[3]	$18,148,934
Projects Focused on Mental Health*	11	1,415[3]	$6,128,211	3,151[3]	$22,714,920
Projects Focused on Substance Use Disorders*	1	60	$511,625	156	$1,862,095
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	3	570	$1,241,861	1,260	$5,153,3
Projects focused on Co-occurring MH/SA	3	95[4]	$1,946,421	205[4]	$7,051,151
Projects Focused on Co-occurring IDD/BH	1	55	$399,942	115	$1,339,536
Projects Enhancing Crisis Services	6	880[5]	$3,631,418	1,986[5]	$12,961,114
Projects Enhancing or Using Telehealth	5	1,110[4]	$4,411,453	2,256[4]	$16,538,437
Projects Enhancing Electronic Health Records	1	640	$870,994	1,440	$3,071,255
Projects Using Evidence-based/Promising Practices**	5	420	$1,563,399	930	$6,219,982

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 11 projects. [2] Information provided on 3 projects. [3] Information provided on 7 projects. [4] Information provided on 2 projects. [5] Information provided on 4 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 17 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	8	937	$6,346,059	2,342	$18,207,725
Projects Focused Across the Age Span	2	350	$2,475,114	900	$6,186,625
Projects Focused on Children Only	0	N/A	N/A	N/A	N/A
Projects Focused on Adults Only	6	587	$3,870,945	1,442	$12,021,100
Projects Focused on Mental Health*	5	412	$2,616,163	1,042	$8,059,922
Projects Focused on Substance Use Disorders*	0	N/A	N/A	N/A	N/A
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	2	225	$1,590,482	525	$4,882,878
Projects focused on Co-occurring MH/SA	1	50	$335,700	125	$921,700
Projects Focused on Co-occurring IDD/BH	1	50	$337,880	100	$1,151,178
Projects Enhancing Crisis Services	3	450	$2,920,614	1,200	$7,339,625
Projects Enhancing or Using Telehealth	1	147	$750,000	307	$2,948,607
Projects Enhancing Electronic Health Records	0	N/A	N/A	N/A	N/A
Projects Using Evidence-based/Promising Practices**	3	115	$1,092,080	260	$3,157,878

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

Disclaimers: This data reflects a review of approved project proposals and so may not reflect the current status of 1115 projects. The table summarizes a variety of project characteristics; therefore, individual projects may be represented in multiple categories. Total number of individuals served is provided for the final two years of the project, when impact numbers are required to be tracked; however, projects may plan to serve individuals in earlier years. Total number of individuals served may be provided for a subset of proposals in which this information was provided in the proposal. Individuals may be served across multiple projects; therefore," total individuals served" does not reflect unique individuals. In addition, estimated individuals to be served may not represent the most currently approved impact numbers. Potential incentive payments for project years 2 and 3 have been updated to reflect CMS-approved incentive payments; however, incentives for FFY15-16 are still to be finalized. Project valuation reflects the maximum of all funds a Category 1 or 2 project may earn if it achieves all metric targets.

1115 Waiver Behavioral Health Projects – Summary Tables

RHP 18 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	16	11,439	$16,864,881	24,179[1]	$63,579,282
Projects Focused Across the Age Span	6	7,796	$10,041,294	16,342	$37,431,001
Projects Focused on Children Only	1	375	$978,224	missing	$3,705,774
Projects Focused on Adults Only	9	3,268	$5,845,363	7,462	$22,442,507
Projects Focused on Mental Health*	10	8,839	$14,512,566	18,665[2]	$54,710,201
Projects Focused on Substance Use Disorders*	5	7,273	$11,119,595	15,872	$41,913,055
Projects Focused on IDD*	1	42	$254,354	96	$965,796
Projects Focused on Co-occurring BH/PH	8	3,458	$6,031,398	7,418[3]	$23,147,369
Projects focused on Co-occurring MH/SA	4	7,166	$6,604,134	14,853	$24,647,002
Projects Focused on Co-occurring IDD/BH	2	444	$5,010,482	1,168	$18,704,411
Projects Enhancing Crisis Services	1	1000	$1,199,020	2,027	$4,498,915
Projects Enhancing or Using Telehealth	2	170	$348,655	382	$1,319,636
Projects Enhancing Electronic Health Records	1	128	$94,301	286	$353,840
Projects Using Evidence-based/Promising Practices**	7	1,943	$8,052,479	4,381	$30,229,882

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided for 15 projects in FFY16. [2] Information provided on 9 projects. [3] Information provided on 7 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 19 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	10	615[1]	$3,131,915	1,395[1]	$11,753,709
Projects Focused Across the Age Span	5	305[2]	$2,158,946	706[2]	$8,100,914
Projects Focused on Children Only	0	N/A	N/A	N/A	N/A
Projects Focused on Adults Only	5	310	$972,969	689	$3,652,795
Projects Focused on Mental Health*	5	331	$1,464,789	785	$5,542,845
Projects Focused on Substance Use Disorders*	3	352	$929,619	765	$3,487,640
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	3	276	$802,820	611	$3,014,395
Projects focused on Co-occurring MH/SA	2	176	$253,637	397	$952,236
Projects Focused on Co-occurring IDD/BH	1	23	$795,645	46	$2,941,951
Projects Enhancing Crisis Services	2	184	$983,597	407	$3,647,738
Projects Enhancing or Using Telehealth	3	125	$759,969	334	$2,896,144
Projects Enhancing Electronic Health Records	1	60	$78,549	200	$294,813
Projects Using Evidence-based/Promising Practices**	3	225	$809,284	493	$3,038,652

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
[1] Information provided on 9 projects. [2] Information provided on 4 projects.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
** This represents projects that explicitly referenced an evidence-based or promising practice in their planning documents; it is possible that projects adopted and implemented such practices later in the planning process.

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1115 Waiver Behavioral Health Projects – Summary Tables

RHP 20 Summary	Number of Projects	Total Individuals Served (FFY15)	Potential Incentive Payment (FFY15)	Total Individuals Served (FFY15-16)	Potential Incentive Payment (FFY13-16)
Total Across All Category 1 & 2 Projects	7	3,850	$6,983,542	8,236	$27,087,094
Projects Focused Across the Age Span	4	3,550	$3,068,975	7,536	$11,863,685
Projects Focused on Children Only	0	N/A	N/A	N/A	N/A
Projects Focused on Adults Only	3	300	$3,914,567	700	$15,223,409
Projects Focused on Mental Health*	5	3,650	$4,819,987	7,736	$18,773,234
Projects Focused on Substance Use Disorders*	0	N/A	N/A	N/A	N/A
Projects Focused on IDD*	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring BH/PH	3	577	$3,604,068	1,331	$13,783,523
Projects focused on Co-occurring MH/SA	0	N/A	N/A	N/A	N/A
Projects Focused on Co-occurring IDD/BH	0	N/A	N/A	N/A	N/A
Projects Enhancing Crisis Services	4	3,273	$3,379,474	6,905	$13,303,571
Projects Enhancing or Using Telehealth	5	3,650	$4,632,085	7,786	$17,798,850
Projects Enhancing Electronic Health Records	0	N/A	N/A	N/A	N/A
Projects Using Evidence-based/Promising Practices**	4	2,063	$4,570,787	4,582	$17,566,098

Note: These tables reflect the Category 1 and 2 projects approved by the Center for Medicare and Medicaid Services (CMS) for four-year funding. Please see the full report for further information about the sample.
* This reflects projects targeting individuals with single diagnoses. Projects targeting individuals with co-occurring diagnoses are represented in a subsequent category. Some projects do identify targeting individuals with both single and co-occurring diagnoses, and these are reflected in both categories.
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