

# Specialty Mental Health Services State Plan Amendment (SPA) Stakeholder Comments/Questions and Responses

## ***Process Comments/Questions***

1. Schedule additional stakeholder meeting(s). (received 6/24/10)
2. Will there be a future meeting to discuss revisions to the SPA documents? (received 6/25/10)

Response (1 & 2 above): Yes. The second meeting is scheduled for July 30, 2010.

3. Provide time after that document is prepared for providers to respond and indicate any suggested revisions. (received 6/24/10)

Response: The Department of Mental Health (DMH) and the Department of Health Care Services (DHCS) have asked that stakeholders provide comments on the draft documents provided by July 19, 2010. DMH and DHCS will offer additional comment periods following future revisions to the documents.

4. Will meeting handouts be made available online? (received 6/25/10)

Response: Yes. Meeting materials are posted on DMH's website: [http://www.dmh.ca.gov/Services\\_and\\_Programs/Medi\\_Cal/SPA\\_Stakeholder\\_Meetings.asp](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/SPA_Stakeholder_Meetings.asp).

5. What is the process and timelines for next steps in the SPA development process? (received 6/25/10)

6. Provide a timeline and outline/description of the State's process. (received 7/8/10)

Response (5 & 6 above): DMH prepared and provided to stakeholders a proposed process and timeline document and will present it at the 7/30/10 stakeholder meeting.

7. Provide document as promised by the DMH regarding frequently asked questions. (received 7/8/10)

Response: At the 6/25/10 meeting, DMH committed to providing a document addressing all comments and questions received and responses. This document meets that commitment.

## **Waiver Related Comments/Questions**

1. What do freedom of choice, statewideness, and comparability mean in the context of the waiver, and what is the rationale for waiving those requirements? (received 6/25/10)

Response: Freedom of Choice – The Social Security Act (the Act) (section 1902 (a)(23) allows individuals receiving Medicaid to choose their provider; in other words to have “freedom of choice” to select a provider. However, the Act also contains provisions whereby such “freedom of choice” by a beneficiary can be waived. One of these provisions is Section 1915(b). As stated by the Federal Centers for Medicare and Medicaid Services (CMS): “This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.”

Through the Specialty Mental Health Services Waiver, the Freedom of Choice provision is waived as services are provided by or arranged for by a local mental health plan (MHP) in each county. MHPs have the authority to select and contract with providers while assuring access to medically necessary services. In order for care to be reimbursed through Medi-Cal, with the exception of an emergency psychiatric condition, beneficiaries must receive services either directly from the MHP or from providers under a contract with the MHP.

Statewideness and Comparability – As noted above, there are a few exceptions to the statewide structure for delivery of specialty mental health services. These exceptions make it necessary to waive the requirements for statewideness and comparability. For example, some specialty mental health services in Sacramento and Solano counties are carved out of the specialty mental health services waiver and provided through the Sacramento and Solano general health managed care plans rather than through the MHPs.

2. Will the state consider other options besides renewing existing “freedom of choice” waiver? (received 6/25/10)

Response: DMH and DHCS are open to hearing stakeholder input regarding alternatives to the current waiver program; however, the SPA stakeholder process is focused on the open SPA (#09-004).

3. The provision of mental health services across counties should be standardized. (received 6/25/10)

Response: DMH and DHCS are open to hearing stakeholder input regarding concerns about the provision of public mental health services in California and suggestions for improvements to the system; however, the SPA stakeholder process is focused on the open SPA (#09-004).

## **SPA Related Comments/Questions**

1. Study peer support as added by other states and prepare an additional section in this SPA to add that service to the state plan. (received 6/24/10)
2. How is the state DMH going to work with clients to develop user-friendly regulations for Medi-Cal funding of peer support and consumer-run programs, such as Peer Run Crisis Respite (alternatives to hospitalization)? Your collaboration/leadership is needed to fund and sustain these cost-effective programs. (received 6/25/10)
3. Peer Support and Parent Partners services and provider types should be included in the SPA. (received 6/25/10)
4. Some time ago, ACHSA drafted a paper (which is attached) on what services we felt needed to be included as billable recovery model services. I understand that you are accepting comments on the draft definitions. We will review the document and try and provide you with comments in addition to the attached paper. (received 7/2/10; referenced document on file with DMH)
5. How will the SPA address peer support and other best practices which have been developed post the early 1990's when the Waiver and the SPA were first done? (received 7/8/10)

Response (1 – 5 above): The State welcomes stakeholder input regarding adding new services and provider types to the State Plan. DMH and DHCS appreciate the importance of peer-lead mental health services and other best practices and are committed to working with stakeholders on considering the addition of peer support and/or other services. The topic of peer providers will be discussed at the July 30, 2010 meeting.

6. How were the definitions in the SPA developed? (received 6/25/10)

Response: The service definitions in the SPA Coverage section have been purposefully and thoughtfully expanded upon at the request of CMS. Service definitions were developed from various sections of Title 9, California Code of Regulations (CCR), Chapter 11 that describe different aspects of the services and the contract between DMH and the County MHPs. In the current State Plan, covered mental health services are merely listed under Rehabilitative Mental Health Services. The proposed definitions illustrate different aspects of the various services. In addition to the update of the service definitions, the provider qualifications were expanded to include minimum qualifications for each provider type providing services. The requirements for the different provider types were developed from the Business and Professions Code, Department of Consumer Affairs – Board of Behavioral Sciences, and Title 9, CCR, Chapter 11. Descriptions of Targeted Case Management (TCM) and Inpatient Psychiatric

Hospital Services have been moved to separate sections of the State Plan that specifically address those services.

7. Prepare a document that shows what changes have been made to the existing definitions (what is attached simply shows the new definitions but does not make it easy to see how they differ from the previous versions). (received 6/24/10)
8. Need to be able to differentiate between the proposed SPA language and the language in the sources from which it was developed. (received 6/25/10)
9. I just wanted to follow up about our request for an annotated copy of the proposed changes. That information will be necessary for us to conduct a thorough and thoughtful review of the proposal. Any idea when that document might be available? Once we get that, we'll need at least two weeks for our review and comment. (received 7/6/10)
10. As mentioned during the meeting, we will need more than two weeks to review the proposed material with our members. Before we can even share the draft with our members we will need a draft of the proposed language that includes old language deleted and new language added. Draft regulations are circulated with a line through deleted language and a line under new language added. That would work well for this draft. (received 7/7/10)
11. More clarity is needed on what changes are being proposed by the Administration as compared to the existing Waiver and State Plan Amendment. (received 7/8/10)

Response (7 – 11 above): DMH and DHCS have prepared and distributed an annotated version of the Rehabilitative Mental Health Services document that was provided at the 6/25/10 meeting. The annotated version identifies statutory, regulatory, and other authoritative source documents that were used to create the proposed SPA language. In addition, the annotated version identifies in strikeout/underline format, differences between the proposed SPA language and the language from the sources documents.

12. "Other Qualified Provider" language should be clarified. (received 6/25/10)

Response: The State agrees that "other qualified provider" needs to be defined, and this is consistent with the direction we have received from CMS. We are moving forward with developing this language and welcome stakeholder input regarding the definition of this term.

13. Further clarification of Early and Periodic Screening Diagnosis and Treatment (EPSDT) services as they relate to the SPA and any changes to this program is needed. The full, intact EPSDT program must continue. (received 6/25/10)

14. Provide the EPSDT portion of the proposed State Plan Amendment since this was not available. (received 7/8/10)

Response (13 & 14 above): The existing EPSDT State Plan language has been distributed to all stakeholders. The state does not intend to change EPSDT services available to children under the State Plan or waiver.

15. Some of the proposed SPA language is not appropriate for children. Clarification regarding “Restore” and “Improve” in EPSDT language is needed. (received 6/25/10)

Response: Please see response to #16 (1<sup>st</sup> paragraph).

16. Absence of “Developmental” and “Maintenance” language in the SPA is a concern. “Maintenance” language is a vital component of the provision of mental health services. (received 6/25/10)

Response: DMH and DHCS are moving forward with developing this language and welcome stakeholder input regarding on these areas. Proposed language will ensure that children who have not lost a functional ability but that need services to assist them in achieving appropriate developmental milestones are eligible to receive those services. The State also welcomes stakeholder suggestions of language that would specify this assurance of proper coverage for children.

DMH and DHCS are moving forward with developing language that explains “maintenance” without using that term and are seeking stakeholder input regarding language that could replace the term “maintenance.” On July 9, 2010, CMS clarified that they have no intention of changing the scope of the rehabilitative mental health services or program; however, they are requiring the state to explain the concept of “maintenance” without using that term.

17. What if a mental health client has a chronic condition and has achieved his/her highest level of functioning as established over a number of years? If there is no reduction of mental disability would this person be denied Specialty Mental Health Services? What if this person shows no restoration because the current level of functioning is higher than any level of functioning in prior years? What if no improvement can be made? Would this person be denied specialty mental health services? If so what then? (received 6/25/10)

Response: Please see response to #16 (2<sup>nd</sup> paragraph). The rehabilitative option allows the concept of “maintenance” however, CMS objects to the use of that term. Therefore, if a client achieves his/her maximum level of functioning, services will not be discontinued if no further improvement, restoration, or reduction of mental disability occurs. Services can continue in order to prevent

loss of function or deterioration as long as the client continues to meet medical necessity criteria.

18. Is CMS asking for more clarification of definitions so that they can find more reasons to deny services?

Response: No. CMS has been very clear that their expectation is not a reduction or limitation of existing services. They are simply asking for more detail in the State Plan to update it and to make it consistent with current practice.

19. Deletion of reference to the phrase, "included but not limited to" is a concern. (received 6/25/10)

Response: References to "included but not limited to" were removed at CMS' request. CMS is concerned that it is an ambiguous phrase that does not identify everything that could be provided under a specific service. Current proposed language in most cases indicates, "includes one or more of the following." We recognize that these two phrases do not have the same meaning and welcome input on an acceptable phrase that is not open-ended but that captures all existing service activities. CMS clarified on 7/9/10 that they prefer the current proposed language ("includes one or more of the following").

20. Telemedicine should be addressed in the SPA. (received 6/25/10)

Response: The SPA Coverage language describes covered services. The Federal Medicaid statute (Title XIX of the Social Security Act) allows the use of telemedicine as an alternative method of providing a covered service, but does not recognize it as a distinct service. The State will consider amending the SPA to include that telemedicine is an allowable method by which to provide some of the rehabilitative mental health services.

21. Is family therapy language included in the Coverage section of the SPA? (received 6/25/10)

Response: Family therapy is included in the coverage section of the SPA. In the limitations of services under section 13.d. Rehabilitative Mental Health Services the definition of "Therapy" includes the statement "Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy at which the beneficiary is present."

22. Will Therapeutic Behavioral Services (TBS) language be included in the EPSDT language in the SPA? (received 6/25/10)

Response: It is not yet determined how or if TBS will be specifically identified in the SPA.

23. Why is California limited to less than the maximum federally allowable amount of days of Targeted Case Management (TCM) for beneficiaries transitioning back into the community (federal maximum is up to 180 days and California allows up to 30 calendar days for a maximum of three consecutive periods of 30 calendar days or less prior to the discharge of a covered stay in a medical institution)? (received 6/25/10)

Response: The final TCM rule as posted in the Federal Register/Vol. 74, No. 124 dated Tuesday, June 30, 2009 provides the following information about reimbursement of TCM services provided to beneficiaries transitioning from medical institutions to the community.

"Guidance from the July 25, 2000 State Medicaid Directors Letter, Olmstead Update No. 3, will continue to provide the parameters under which States may receive reimbursement for case management services for the purpose of transitioning from medical institutions to the community. TCM, as defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution in order to facilitate their transition to community services and enable them to gain access to needed medical, social, educational and other services in the community. TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay for the purpose of community transition. States may specify a shorter time period or other conditions under which targeted case management may be provided."

In accordance with these requirements, California has determined that, as it applies to the specialty mental health program, a period shorter than 180 days is adequate to provide TCM for the purpose of assisting a beneficiary in transitioning from an institution to the community. California has also specified the condition that these TCM services be limited to coordinating placement. Assuming that the beneficiary meets the medical necessity criteria for specialty mental health service, the service is available during the 30 days prior to discharge and, if discharge does not occur as planned and new linkages need to be established for the beneficiary, TCM placement services can be provided for two additional non-consecutive periods of up to 30 calendar days each. This stipulation can be found in Section 1840.374 "Lockouts for Targeted Case Management Services" of the California Code of Regulations Title 9, CCR, Chapter 11.

Additional research and analysis is needed to determine the original rationale for establishing the 90 day time frame, if the existing timeframe is adequate, and if the 90 day timeframe can be changed if determined necessary.