

Mental Health State Plan Amendment Question/Comment and Response Summary

The Department of Mental Health (DMH) received extensive questions, comments, and suggested language edits throughout the State Plan Amendment (SPA) stakeholder process that began in June 2010. The following table is a summary of stakeholder questions and comments with DMH responses. DMH received several stakeholder questions and comments that were very similar in nature. Therefore, the following table represents consolidated and paraphrased questions and comments. This approach is being used in an attempt to create a more concise, user-friendly document. DMH has all original stakeholder questions and comments as submitted on file. Additional information describing State and stakeholder discussions can be found in the SPA Stakeholder meeting notes.

Topic	Question/Comment	Response
General	How were the definitions in the SPA developed?	The service definitions in the SPA Coverage section have been fully vetted in collaboration with DHCS and CMS in order to reflect current services provided under the specialty mental health waiver. Carefully selected language from various sections of Title 9, California Code of Regulations (CCR) and the DMH/Mental Health Plan (MHP) contract was used to craft these definitions. The current State Plan covered mental health services definitions have not been updated since the waiver was implemented and do not accurately reflect current services. 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.
General	The State Plan descriptions and descriptions in Title 9 should be consistent with one another. The two descriptions should be further aligned so that there are no internal inconsistencies to the descriptions. If the State does not intend to change state regulations, they should be incorporated by reference in the State Plan.	The State Plan is the authority to provide services and for purposes of this document, more general descriptions are used. Title 9 uses more specific language that applies to MHPs. Both sources govern the provision of Medi-Cal specialty mental health services in California. Title 9 may be amended in the future for consistency with updated definitions in the State Plan. Based on CMS guidance, referencing state regulations in the State Plan is not permitted. Regulations may be amended often and if citations of regulations are included in the State Plan, this would also require a SPA each time this occurs.
General	Several stakeholders expressed concern about the absence of references to Mental Health Plans (MHPs) and the inclusion of references including, “as required by state	The term MHP is a construct of the 1915(b) waiver and, per CMS direction, cannot be referenced in the State Plan. If the waiver was discontinued; the State Plan must maintain the authority for the provision

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	law.”	of mental health services. To accommodate for CMS’ request, references to MHPs have been removed from the SPA documents.
General	The federal definition of “medical necessity” may be too narrow. “ <i>Psychosocial necessity</i> ,” as used in the services contract between the State of Iowa and its behavioral health contractor is much more appropriate in the context of psychosocial and psychiatric rehabilitation. Under this definition, treatment decisions must take into consideration the enrollee’s clinical history, the potential for services/supports to avert the need for more intensive treatment, and any unique circumstances that may make particular services inaccessible or inappropriate for an enrollee.	The State is not changing the term or meaning of “medical necessity” in this SPA. Changing the definition or meaning of medical necessity, or changing the term used to describe a key component of how beneficiaries are eligible for receiving services would be a significant change to existing practice and would not be consistent with CMS’ direction of updating the State Plan to be consistent with current practice. Changes to existing services, practices, or service delivery may be considered at a later time.
General	Is family therapy language included in the Coverage section of the SPA?	Family therapy is included in the definition of “Therapy” in the Rehabilitative Mental Health Services SPA document which states in part that “Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy at which the beneficiary is present.” Family therapy must be provided in the context of the needs of the beneficiary as identified in his/her client plan where the beneficiary remains the “client” not the family.
General	"Psychiatrist Services" and "Psychologist Services," are not in the SPA definitions of covered services, although they are in the Title 9 definitions of covered services. They should be listed in the SPA as well as Title 9.	Psychiatrist services and psychologist services are not listed as separate service categories in the draft SPA because they are not actually separate reimbursable service types. Services provided by psychiatrists and psychologists are captured under other service categories, e.g., mental health services, or medication support services.
General	Is CMS asking for more clarification of definitions so that they can find more reasons to deny services?	No. CMS has clearly stated that their expectation is not to reduce or limit existing services, but rather to update the State Plan to provide more detail and make it consistent with current practice.
Stakeholder Suggested language	The State received multiple recommendations for specific language changes for the SPA documents. Most of these suggestions pertained to descriptions of services or service activities.	The State found stakeholder language suggestions helpful and valuable. The State carefully and thoroughly considered all stakeholder input and suggested language and, where possible and appropriate, accepted recommended language changes, or portions of suggested language changes. Language recommendations that were too detailed for the State Plan or that constituted expansions to current services were not incorporated into the revised SPA documents.

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EPSDT / Children	<ul style="list-style-type: none"> Several stakeholders expressed concern that service descriptions do not address specific needs of children and youth, are not appropriate for children and youth, and do not describe how services should be provided or tailored to meet the needs of children as distinct from adults. "EPSDT Supplemental Specialty Mental Health Services" are not in the SPA definitions of covered services, although they are in the Title 9 definitions of covered services. They should be listed in the SPA as well as Title 9. 	<p>The State has carefully considered stakeholder input regarding this concern and has revised draft SPA language to include child-specific language throughout the SPA documents. For example, language has been added to the "Rehabilitative Mental Health Services" section that states in part "Rehabilitative Mental Health Services include services to enable a child to achieve age-appropriate growth and development. It is not necessary that a child actually achieved the developmental level in the past.</p> <p>EPSDT language contained in the SPA will be left broad to include all rehabilitative mental health services, TCM, and other services not specifically listed in the State Plan. Specific services, including Therapeutic Behavioral Services (TBS) are not specifically listed in the EPSDT section so as not to imply that TBS is the only EPSDT service available.</p>
"Maintenance"	<p>Several stakeholders expressed concern regarding the deletion of the terms "maintenance" or "maintain," expressing that "maintenance" language is a vital component of the provision of cost-effective and appropriate rehabilitative mental health services.</p> <p>Some stakeholders interpreted the deletion of these references to mean that if a beneficiary achieved his or her highest level of functioning and there was no further reduction of impairment that this person would be denied Specialty Mental Health Services.</p> <p>DMH received stakeholder input on suggestions for explaining the concept of maintenance.</p>	<p>On July 9, 2010, CMS clarified that they do not intend to change the scope of what is allowable under rehabilitative mental health services; however provided guidance that the term "maintenance" should not be used. Therefore, the current draft SPA documents explain the concept of maintenance and emphasize recovery and resiliency.</p>
"Including but not limited to"	<p>Several stakeholders expressed concern regarding the deletion of references to the phrase, "included but not limited to."</p>	<p>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." The State recognizes that these two phrases do not have the same meaning, but believes that the current draft language adequately</p>

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		captures existing services and is responsive to CMS guidance. CMS clarified on 7/9/10 that they prefer the current proposed language (“includes one or more of the following”).
Telemedicine	<ul style="list-style-type: none"> • Telemedicine should be addressed in the SPA. • Mental Health Services and Medication Support Services should be either face-to-face, by telephone <i>or through electronic communication</i>. This language is important in light of the reality of how mental health services are delivered, especially in rural counties, where “services via videoconferencing” is a necessity. 	<p>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 some covered services, but does not recognize it as a distinct service. Telemedicine continues to be an allowable method by which to provide some of the rehabilitative mental health services.</p> <p>The state is will revise the SPAs to include a definition of telemedicine and specify that telemedicine is an allowable means of service delivery for mental health services, medication support, crisis intervention, and TCM. The term “telemedicine” will be used, consistent with the CMS definition of that term.</p>
Rehab. MH Services/ Definitions: “Assessment”	The service category, “evaluation” is intended to support the evaluation of outcome measures or psychological testing for mental health recipients. Can outcome and other evaluation methods be supported under “assessment”?	“Evaluation” is part of the definition of “assessment” in the Rehabilitative Mental Health Services SPA.
Rehab. MH Services/ Definitions: “Plan Development”	The plan development definition/description should make it clear that it includes development of a crisis plan.	Development of a crisis plan is a clinically appropriate activity and may be part of the client plan, or could be a separate plan developed under the existing definition of plan development.
Rehab. MH Services/ Definitions: “Referral”	“Referral” is a new service category that might be in conflict with Case Management Placement Services. “Referral” is not a service that is provided to a beneficiary; it is something that is done on behalf of the beneficiary.	“Referral” is not intended to describe a direct service. CMS requested that the State define the term “referral” in the State Plan. It is listed under the definitions section which is not limited to definitions of services or service activities.
Rehab. MH Services/ Definitions: “Waivered/ Registered	Why isn’t there any mention of the “waivered” status we currently allow for mental health services?	The revised SPA documents specify that services may be provided by waivered/registered professionals where appropriate.

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Professional”		
Rehabilitative Mental Health Services	The Rehabilitative Mental Health Services description should provide more detailed descriptions for home and community-based services and interventions including types of services that can be provided in the community, and emphasize the best practices and evidenced-based treatments with clients and families in the community. Why are the limitations (which often focus on technical billing issues that have nothing to do with services descriptions) appropriate to include here as opposed to in a billing or operational manual?	This would type of description is too detailed for the State Plan. CMS requires the limitations sections following the description of each service.
Rehabilitative Mental Health Services	Can these services only be recommended by a physician or other licensed mental health professional?	Yes. Rehabilitative Mental Health Services must be recommended by a physician or other licensed mental health professional, but may be provided by other qualified providers as determined by the MHP.
Rehab. MH Services: Medication Support Services	The phrase, “...managing the process to reduce medication usage of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness” seems contradictory.	The current draft SPA language has been edited for greater clarity in this section. Medication Support Services now reads, “are those services that include one or more of the following: prescribing, administering, dispensing, monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering an symptoms of mental illness.”
Rehab. MH Services: Day Rehabilitation and Day Treatment Intensive	Stakeholders expressed concern over the deletion of “adjunctive therapies” in the day rehabilitation and day treatment intensive sections, stating that adjunctive therapies were essential component of those services.	Originally, CMS recommended removing “adjunctive therapies” and stated that adjunctive therapies were not Medicaid reimbursable. CMS later advised the State that it would consider adjunctive therapies once the State described the service and appropriate reimbursement methodologies. Initial stakeholders’ feedback on adjunctive therapies was that the term/description was outdated. Following further discussion at the October 6, 2010 stakeholder meeting, the consensus was to include the term adjunctive therapies in the SPA.
Rehab. MH Services: Day Rehabilitation and Day Treatment Intensive	Stakeholders expressed concerns about existing requirements as follows: "Process Groups" and "Psychotherapy" for some people some of the time may be appropriate, but should not be mandated as part of a service array, especially since it would require many more licensed practitioners than the	These are required components of Day treatment intensive as specified in the contract between DMH and Mental Health Plans (MHPs) and Title 9 regulations. Changing these requirements in the State Plan would change existing practice and is therefore outside of the scope of the current SPAs. However, language in the revised SPA drafts includes Day rehabilitation and Day treatment sections that are much less detailed than the previous drafts based on the determination that the previous drafts had too much

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	<p>system has available. Most folks need individual and group rehabilitative mental health services more than they need therapy.</p> <p>A person in a day program should not have to get special approval for individual or group services outside day program hours on the same day. The effect is staff spending time on authorization paperwork, or forcing the person to spend time and resources making a second trip on a different day.</p>	<p>detail for a State Plan.</p>
<p>Rehab. MH Services: Crisis Intervention</p>	<p>The crisis intervention definition should include more clarity on what constitutes an “emergency” response. Also, crisis interventions should be a standalone service or should define how other services such as collateral, assessment, therapy, etc. are supported during a crisis intervention.</p>	<p>The description of crisis intervention has been edited in the current draft of the SPA to better describe the service, however providing a definition of “emergency response” is too detailed for the State Plan and could be limiting if the definition did not include everything that might be considered an appropriate emergency response. Collateral, assessment, and therapy are service activities under broader service types, including crisis intervention. The limitations section identifies services that cannot be provided on the same day as crisis intervention.</p>
<p>Rehab. MH Services: Crisis Residential and Adult Residential Services</p>	<p>Deletion of Title 9, Chapter 3 references for certification/licensing requirements for crisis residential and adult residential services creates ambiguity. Does deletion of this sentence signify that certification of these programs is required elsewhere in the legal or regulatory landscape or that certification is no longer required?</p>	<p>Based on CMS guidance, referencing state regulations in the State Plan is not permitted. Regulations are amended often and if citations of regulations are included in the State Plan, this would also require a SPA each time this occurs. The certification requirements are in effect and continue to exist in Title 9, Chapters 3 and 11.</p>
<p>Rehab. MH Services: Crisis Residential and Adult Residential Services</p>	<p>Not all adult or crisis residential programs offer psychotherapy. The current sentence structure that reads “Services in all programs include:” does not allow for needed flexibility in service delivery.</p>	<p>Language in the revised SPA drafts includes crisis residential and adult residential sections that are less detailed than the previous drafts based on the determination that the previous drafts had too much detail for a State Plan. The current draft language does not indicate psychotherapy as a requirement for either service and does not include the phrase, “services in all programs include.”</p>
<p>Provider Qualifications</p>	<p>The Provider Qualifications section describes who can provide services and who is qualified to provide supervision of others. The term “certified” is used but not</p>	<p>The term “certified” refers to mental health organizations or agencies and is described in the contract between DMH and MHPs and in Title 9, CCR, Section 1810.435.</p>

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	defined.	
Provider Qualifications	Staff who function as “Heads of Service” indicate that they must be licensed, as there’s no mention of a waived staff. Also, there isn’t a definition for “Head of Service”.	References to Head of Service have been removed from revised drafts of the SPA documents because the Title 9, Chapter 3 requirements for Head of Service are not specific to the Medi-Cal program and are therefore not appropriate to include in the Medicaid State Plan.
Other Qualified Provider	Several stakeholders had concerns over the proposed definition of “Other Qualified Provider” and requested clarification on what types of individuals could be considered as other qualified providers.	DMH has made changes to this definition based on stakeholder input and direction from CMS to clarify this definition. The revised draft definition of “other qualified provider” is intentionally broad in order to not limit what is currently allowed while providing some basic, minimum qualifications. The definition is intended to include peer support, parent partners, and paraprofessionals who meet the minimum requirements. Other qualified provider will be added to the Targeted Case Management SPA documents as it was originally omitted in error.
TCM	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 non-consecutive periods of 30 calendar days or less prior to the discharge of a covered stay in a medical institution)?	<p>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.</p> <p>"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."</p> <p>In accordance with these requirements, California has determined that, as it applies to the specialty mental health program, a period shorter than 180</p>

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		<p>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.</p>
TCM	<p>There is nothing mentioned in the description of monitoring and follow-up that addresses transitioning levels of care or from one type of mental health service to another. In addition, it is unclear how the monitoring and support and assistance of the client is different from rehabilitative mental health services.</p>	<p>The TCM SPA is based on a CMS "pre-print" (template) that contains federally required language that the State has limited flexibility to change. How transitioning is accomplished varies and is not specifically defined or regulated. The services described in the Rehabilitative Mental Health Services SPA are direct services. TCM is more general assistance in connecting with needed services.</p>
TCM	<p>The "placement coordination services" description should read: "least restrictive environment" instead of "out-of-home placement."</p>	<p>The State has made this change in the current drafts of the SPA.</p>
TCM	<p>Should the frequency of assessment under TCM state that such assessments would be provided more than annually, when medically necessary or appropriate? Annually is very infrequent. Is this meant to be a minimum standard?</p>	<p>Assessments may be provided as determined to be needed by the beneficiary. The language regarding annual assessment is the minimum requirement. The assessment language under TCM is regarding an assessment for TCM services. Additional assessments may be provided for non-TCM services.</p>
TCM	<p>The description of TCM services should address the types of TCM services activities that may be provided to specifically meet the needs children and youth (e.g. related to school, etc.), as distinguished from adults.</p>	<p>The State has carefully considered stakeholder input regarding this concern and has revised draft SPA language to include child-specific language throughout the SPA documents. For example, language referencing schools, and transition plans for children has been added.</p>
Peer Support	<p>Several stakeholders requested that the State add Medi-Cal reimbursable Peer Support services and providers to the current SPA.</p>	<p>The State is open to stakeholder input regarding peer support services and will consider making that service available in the future. The purpose of the current SPAs is to update the service definitions and provider qualifications to be consistent with current practice.</p> <p>Peer support and parent partner providers may be specifically included in</p>

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		<p>the future and will be considered in conjunction with the addition of peer support services. Peer support providers and parent partners are currently covered in the draft SPA language under the very broad definition of “other qualified provider.” Other qualified providers may provide some existing services under the direction of a licensed mental professional that can direct services.</p>
Waiver	<p>What do freedom of choice, statewideness, and comparability mean in the context of the waiver, and what is the rationale for waiving those requirements?</p>	<p>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.”</p> <p>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.</p> <p>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.</p>
Waiver	<ul style="list-style-type: none"> • Will the State consider other options besides renewing existing “freedom of choice” waiver? 	<p>The State is open to stakeholder input regarding alternatives to the current waiver program; however, the SPA stakeholder process is focused on the</p>

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	<ul style="list-style-type: none"><li data-bbox="394 321 989 376">• The provision of mental health services across counties should be standardized.	current SPAs.