Response to Formal RAI Responses ME 10-014

General Comments:

CMS asked for an assurance from the State in an e-mail dated May 2, 2011 and in our initial questions to clarify that all qualified providers are allowed to provide the behavioral health services outlined in this State plan, and are not restricted to Mental Health Agencies.

The State responded to this question in an e-mail dated May 2, 2011, with the following assurance:

"These services are not limited to licensed mental Health agencies for the most part. Qualified independent practitioners may also enroll to provide many of these services, such as therapy services. However, for some of the services that require more coordination, one provider requirement is to be a licensed mental health agency, as only an agency can provide that team approach that is crucial for continuity of care. For instance, when ACT services are required, which is a team approach, a qualification for a provider is to e a licensed mental health agency. In any event, we have many mental health agencies enrolled, so a member always has a choice of which agency they receive services from.

Coverage Comments:

1) Behavioral Health Services

- Section 1902(a)(23) of the act requires providers and their qualifications are defined for services provided. The State needs to provide descriptions for Psychological Examiner and Psychologist.
- 42 CFR 440.130(d) requires services be recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, for the maximum reduction of physical or mental disability and restoration of a recipient to his best best possible functional level. To comply with regulation CMS advises the state to include this language in the plan.

2) Crisis Resolution

- The State needs to provide written assurance, consistent with 1902(a)(23) of the Social Security Act, that if any willing and qualified Medicaid provider exists they may tender services to participants.
- It appears that there is a Typo on last paragraph of 7a: Licensed Professional Clinical Counselor should be Licensed Clinic Professional Counselor...or is this separate provider?

3) Crisis Residential

- The State needs to provide a written assurance, consistent with 1902(a)(23) of the Social Security Act, that if any willing and qualified Medicaid provider exists they may tender services to participants.

4) Outpatient Services – Assessment and Therapy
   - The State needs to provide an assurance that services are not provided in IMD.
   - 2nd paragraraph states, "..., and may include Affected Others and similar professional therapeutic services..." The State needs to describe was is meant by Affected Others.

5) Family Psychoeducational Treatment
   - It is not clear from the service description what is actually being provided. The State needs to clarify their description of this service.
6) Intensive Outpatient Services (IOP)
   - The State needs to provide a more concise and detailed discussion of what this delivery model would look like.
7) Children's Assertive Community Treatment (ACT)
   - The services are bundled. This is a problem for reimbursement, and for coverage CMS has concerns that the medication services are rolled into this service.
8) Children's Home and Community Based Treatment
   - The State needs to provide a written assurance, consistent with 1902(a)(23) of the Social Security Act, that if any willing and qualified Medicaid provider exists they may tender services to participants
   - The services states, "...teaching the member and family or caregiver how to appropriately and therapeutically respond to the member's identified treatment needs" This needs to be removed.

11) Collateral Contacts

- The State needs to clarify how this service is different from case management?

12) Opioid Treatment

- Reimbursment for administration of medication is okay, but the State needs to remove the actual Medication from the plan, this should be under pharmacy.

13) Childrens Behavior Health Day Treatment

- In the 3rd paragraph the language reads as if the family is entitled to 6 hours of their own treatment. The State needs to clarify that services are only provided to the Medicaid eligible individual?

14) Intensive Integrated Neurorehabilitation

- It appears that the State mistakenly put this service in this section of the plan. The State needs to state their intent.

15) Community Support Services

- The State indicates that this service is different than the community support because it is specific to SPMI population. But Community integration is also SPMI. There are subtle variants between the two but it is not clear why the two services could not be combined. The State needs to explain how they are so different.

16) Community Rehab service is included as a service, but the State needs to provide an actual description of the service.

18) Assertive Community Treatment

- The State needs to provide an assurance that the service is not provided in an IMD.
- The State needs to define how this service is different from Children's ACT?

19) Daily Living Supports

- The State needs to explain how they can monitor how this service would not be duplicated within another service.
- The State needs to provide an assurance that this service is not provided in an IMD.
- What does this look like in the real world?

20) Skills Development

- The State indicates that the service is not duplicative, but it's provided under other services just like daily living supports. Again, the State needs to provide a discussion as how this service does not duplicate other services.
- The State needs to provide an assurance that the service is not provided in an IMD.
- The component of this service of teaching based to increase independence and the descriptions sound a lot like habilitative services case management. The State needs to clarify how this service is different.

21) Behavioral Health Day Treatment

- The questions asked in 19 and 20 apply to this service as well.

22) Specialty Group Services

- State indicates there is only one provider of services. The State needs to provide written assurance, consistent with 1902(a)(23) of the Social Security Act, that if any willing and qualified Medicaid provider exists they may tender services to participants
- The State needs to explain how the cap placed on are NF eligible up to 40 hours meets the sufficiency requirements. Is the cap a hard limit, or can the State authorize additional hours if medically necessary?
- The State needs to describe the MED tool.