STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: April 26, 2017

TO: All Members of the Delaware State Senate
and House of Representatives

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: H.B. 100 (Substance Abuse Treatment)

This legislation was introduced on March 23, 2017. It passed the House on April 4, 2017. As of April 10, it awaited action by the Senate Health, Children, & Social Services Committee. The attached fiscal note indicates that the Department of Justice would use existing funds derived from its Consumer Protection Fund to cover the costs of implementation. The legislation would "sunset" on January 1, 2020 unless reauthorized prior to that date.

The State Council for Persons with Disabilities (SCPD) has reviewed H.B. 100, which seeks to address insurer denial of substance abuse treatment, in whole or in part, including refusal to approve an appropriate type or duration of treatment (lines 5-7). The legislation posits that many insured individuals lack the means to challenge such denials (lines 13-14). The Delaware Department of Justice would be authorized to use Consumer Protection Funds to provide legal and expert assistance to such aggrieved individuals (lines 22-33). Assistance could include direct representation as well as retention of auditors and experts (lines 24 and 37-40). Insurers subject to the jurisdiction of the Delaware Insurance Commissioner would be required to include disclosure of the potential availability of DOJ assistance in written grievance forms (lines 51-53). DHSS would be required to ensure that Medicaid beneficiaries receive similar notice of the potential availability of DOJ assistance (lines 69-74).

SCPD has the following observations.

First, the scope of the private insurers required to provide the notice would ostensibly be limited to those insurers subject to Delaware Department of Insurance jurisdiction. As the Synopsis

recites, employer-funded health benefit plans are typically exempt from state regulation. We believe that most health insurers providing coverage in Delaware are covered by federal ERISA and therefore exempt from the jurisdiction of the Delaware Department of Insurance. However, the DOJ could still provide valuable assistance to aggrieved individuals under private plans not regulated by the Delaware Department of Insurance (line 25 and Synopsis).

Second, there is some potential for a conflict of interest since the DOJ represents the State Medicaid agency, the Division of Medicaid & Medical Assistance (DMMA). The Medicaid MCOs are State contractors who are acting on behalf of the State. This potential conflict is mitigated in the Fair Hearing context since the MCO, not DMMA, presents the case and defends its decision. See 16 DE Admin Code 5304.3. However, a potential conflict also arises in the following contexts:

A. A State DMMA employee serves as 1 of 3 decision-makers for internal MCO appeals. See attached excerpt from DMMA-MCO contract, §3.15.3.2.8.

B. DOJ advocacy to secure enhanced substance abuse services for a Medicaid beneficiary may result in fiscal obligations of the State Division of Behavioral Health Services or State Division of Substance Abuse & Mental Health which are represented by the DOJ. See attached excerpt from DMMA- MCO contract, §§3.4.10.9.1, 3.4.10.9.2, 3.8.9.9 and 3.8.9.10 and Appendix 1.

Third, the Synopsis suggests that the Sunset provision is intended to permit assessment of the efficacy of the bill. Apart from authorizing DOJ assistance to individuals denied substance abuse treatment, policymakers could also consider supplemental options. For example, legislation or regulations could be prepared to:

A. uniformly impose the burden of proof and persuasion on the insurer/MCO in disputes concerning substance abuse treatment;
B. make the opinion of the treating prescriber controlling unless clearly erroneous as documented by production of clear and convincing evidence;
C. require any benefit of doubt regarding prescribed substance abuse treatment to be resolved in favor of eligibility; and/or
D. encourage a robust independent medical assessment if substance abuse treatment is denied (consistent with attached §3.4.7 of DHSS-MCO contract).

Compare H.B. No. 459 from the 142nd General Assembly.

SCPD is endorsing the proposed legislation while noting that policymakers could also consider supplemental approaches to addressing denials of substance abuse treatment.

Thank you for your consideration and please contact SCPD if you have any questions regarding our position or observations on the proposed legislation.

cc: The Honorable Matthew Denn, Attorney General's Office
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council
HB 100 substance abuse treatment 4-24-17

149th GENERAL ASSEMBLY
FISCAL NOTE

BILL:	HOUSE BILL NO. 100
SPONSOR:	Representative Keeley
DESCRIPTION:	AN ACT TO AMEND TITLES 6, 16, 18, AND 31 OF THE DELAWARE CODE RELATING TO TREATMENT FOR SUBSTANCE ABUSE.

Assumptions:

1. This Act would become effective 120 days after enactment.

2. This Act would provide persons with private and public insurance coverage that were denied substance abuse treatment, in whole or in part, be notified that they may be eligible to receive legal assistance from the Department of Justice in appealing the claim denial by the Department of Health and Social Services.

3. This Act would require the Insurance Commissioner to be responsible for providing the necessary language for the required written forms for the submission of grievances related to denial of benefits. This Act also requires the Medicaid program and private insurance carriers to provide notice to persons who are denied substance abuse treatment of the possibility of legal assistance through the Department of Justice to challenge their claim denials.

4. This Act would allow the Department of Justice to provide legal and expert assistance to persons seeking benefits from the state's Medicaid program, traditional health plans, or employer-funded benefit plans.

5. This Act would allow the Department of Justice to use Appropriated Special Funds (ASF) in its Consumer Protection Fund to offset the cost of providing medical and legal expertise for the purpose of assisting these persons. The Consumer Protection Fund is an Appropriated Special Fund (ASF Funds). Revenue for this fund is generated from settlements of consumer fraud. There would be a fiscal impact on the Consumer Protection Fund, but the extent of the impact is indeterminable due to the unknown levels of demand or utilization of the resources proposed in this Act.

6. This Act contains a sunset provision set to expire on January 1, 2020 to allow for review and assessment of the impacts of this legislation prior to making these provisions permanent.

Cost: Appropriated Special Funds (ASF)

Fiscal Year 2018:	Indeterminable
Fiscal Year 2019:	Indeterminable
Fiscal Year 2020:	Indeterminable

Prepared by Spencer Price
Office of the Controller General

3.4.6.10.3 The Contractor shall collaborate with DSAMH and/or DDDS (as applicable) and the nursing facility to develop a plan of care that includes all of the Specialized Services specified by the State.

3.4.6.10.4 The Contractor shall coordinate with DSAMH and/or DDDS (as applicable), the nursing facility and the provider(s) providing Specialized Services to ensure that Specialized Services covered by the Contractor are provided to each member as specified by the State as part of the PASRR Level II process.

3.4.7 Second Opinions

3.4.7.1 The Contractor shall provide for a second opinion from a qualified participating Health Care Professional, or arrange for the member to obtain one outside the network, at no cost to the member.

3.4.8 Additional Services

3.4.8.1 Subject to the prior approval of the State, the Contractor may provide services to members that are in addition to those covered under the Medicaid State Plan or otherwise included as a Covered Service. As referenced herein, additional services include "in lieu of" services and "extra" services.

3.4.8.2 If the State determines that an additional service is a cost-effective substitute for a Covered Service, the State may provide credit for the "in lieu of" service in rate setting. The Contractor shall perform a cost-benefit analysis for any in lieu of service it proposes to provide, as directed by the State, including how the proposed service would be cost-effective compared to a Covered Service. An additional service will only be considered an in lieu of service if prior approved as such by the State.

3.4.8.3 The cost of an extra service provided by the Contractor will not be reflected in rate setting.

3.4.8.4 If the Contractor will provide an extra service on a routine basis and/or include the service in the member handbook, the extra service shall be prior approved in writing by the State. In accordance with Section 2.1.7 of this Contract, any changes to an extra service must also be prior approved in writing by the State.

3.4.8.5 The Contractor shall not require a member to accept an additional service (in lieu of or extra service) instead of a Covered Service.

3.4.9 Copayments and Patient Liability

3.4.9.1 Copayments for Prescription Drugs

3.4.9.1.1 The Contractor shall comply with the requirements in Section 3.5 of this Contract regarding prescription drug Copayment requirements.

3.4.9.2 Patient Liability (Post-Eligibility Treatment of Income)

3.4.9.2.1 The State calculates the Patient Liability amount, as applicable, for each DSHP Plus LTSS member. The State will notify the Contractor of any applicable Patient Liability amounts via the HIPAA standard 820 Premium Payment file, and the retroactive monthly amounts via the HIPPAA standard 834 Eligibility file.

3.4.9.2.2 For DSHP Plus LTSS members residing in a nursing facility or assisted living facility, the Contractor shall delegate collection of Patient Liability to the facility and shall pay the facility net the applicable Patient Liability amount.

3.4.9.2.3 Per CMS requirements, the Contractor shall ensure that the Patient Liability amount assessed for a member in an assisted living facility is applied only to the cost of HCBS, not to the cost of Covered Services available under the Medicaid State Plan.

3.4.9.2.4 If a member refuses to pay his/her Patient Liability to a facility, the facility may notify the Contractor that it is terminating services to the member. If this occurs, the Contractor shall work to find an alternative facility willing to serve the member. If the Contractor is unable to find an alternative facility, the Contractor shall consult with the State on appropriate next steps.

3.4.9.3 The Contractor and all participating providers and Subcontractors shall not require any cost sharing or Patient Liability responsibilities for Covered Services or additional services except to the extent that cost sharing or Patient Liability responsibilities are required for those services by the State in accordance with this Contract.

3.4.10 Medicaid Benefits Provided by the State

3.4.10.1 General

3.4.10.1.1 Services not covered in the DSHP benefit package or the DSHP Plus LTSS benefit package, but covered under the Delaware Medicaid State Plan or 1115(a) demonstration and provided by the State for DSHP and DSHP Plus members include:

3.4.10.1.1.1 Dental services for children under age 21;

3.4.10.1.1.2 Prescribed pediatric extended care (PPEC) services for children with severe disabilities;

3.4.10.1.1.3 Day habilitation services for persons with developmental disabilities authorized by the Division of Developmental Disabilities Services;

3.4.10.1.1.4 Non-emergency medical transportation;

3.4.10.1.1.5 Specialized Services for Nursing Facility Residents not included in Covered Services;

3.4.10.1.1.6 Employment services and related supports provided through the Pathways program for eligible individuals;

3.4.10.1.1.7 Chiropractic services for alternative benefit plan members; and

3.4.10.1.1.8 Additional behavioral health services (see Section 3.4.10.9 of this Contract, below).

3.4.10.1.2 The Contractor shall coordinate the overall delivery of care with both participating and non-participating providers and State personnel whenever one of its members requires Medicaid benefits provided by the State (see Section 3.8.9 of this Contract for related requirements).

3.4.10.2 Dental Services for Children

3.4.10.2.1 The Contractor is not responsible for dental services except that the Contractor shall provide removal of bony impacted wisdom teeth as a surgery that is a Covered Service under this Contract.

3.4.10.3 Prescribed Pediatric Extended Care (PPEC)

3.4.10.3.1 PPEC is a package of nursing, nutritional assessment, developmental assessment, speech, physical and occupational therapy services provided in an outpatient setting, as ordered by an attending physician.

3.4.10.4 Day Habilitation for Persons with Developmental Disabilities

3.4.10.4.1 Day habilitation services are provided to persons with developmental disabilities under the Rehab Option of the Delaware Medicaid State Plan.

3.4.10.5 Non-Emergency Medical Transportation

3.4.10.5.1 Non-emergency medical transportation is available to all DSHP and DSHP Plus members except DHCP members.

3.4.10.6 Specialized Services for Nursing Facility Residents Not Included in Covered Services

3.4.10.6.1 The State will provide Specialized Services as determined necessary by the State as part of the PASRR Level II process that are not included in the DSHP or DSHP Plus LTSS benefit package.

3.4.10.7 Employment Services and Supports Provided Through Pathways

3.4.10.7.1 The following services are available to members participating in Pathways to supplement Covered Services provided by the Contractor. These services are the responsibility of the State and are paid through the State's MMIS.

3.4.10.7.1.1 Career exploration and assessment;

3.4.10.7.1.2 Job placement supports;

3.4.10.7.1.3 Supported employment – individual;

3.4.10.7.1.4 Supported employment – small group;

3.4.10.7.1.5 Benefits counseling;

3.4.10.7.1.6 Financial coaching;

3.4.10.7.1.7 Non-medical transportation;

3.4.10.7.1.8 Personal care (including self-directed option) (for DSHP Plus LTSS members, the Contractor is responsible for attendant care services that are Medically Necessary per the Contractor's UM guidelines (see Section 3.12 of this Contract)); and

3.4.10.7.1.9 Orientation, mobility and assistive technology.

3.4.10.8 Chiropractic Services for Alternative Benefit Plan Members

3.4.10.8.1 Chiropractic services are provided to members in the MAGI adult group

3.4.10.9 Additional Behavioral Health Services

3.4.10.9.1 *Behavioral Health Services for Children under Age 18*

3.4.10.9.1.1 Behavioral health services provided to members under age 18 beyond those included in the DSHP benefit package are the responsibility of the State. This includes outpatient services beyond what is included in the DSHP benefit package as well as all residential and inpatient behavioral health services.

3.4.10.9.2 *Behavioral Health Services for Members Age 18 and Older who Participate in PROMISE*

3.4.10.9.2.1 As provided in the DSHP benefit package above, the Contractor will no longer be responsible for the following services when a member is participating in PROMISE. For members participating in PROMISE these services become the responsibility of the State and are paid through the State's MMIS.

3.4.10.9.2.1.1 Substance use disorder (SUD) services other than medically managed intensive inpatient detoxification; and

3.4.10.9.2.1.2 Licensed behavioral health practitioner services.

3.4.10.9.2.2 The following services are available to members participating in PROMISE to supplement Covered Services provided by the Contractor. These services are the responsibility of the State and are paid through the State's MMIS.

3.4.10.9.2.2.1 Care management (for DSHP Plus LTSS members refer to Section 3.7 of this Contract for requirements relating to Contractor coordination with care management provided by DSAMH);

3.4.10.9.2.2.2 Benefits counseling;

3.4.10.9.2.2.3 Community psychiatric support and treatment, including ACT/ICM;

3.4.10.9.2.2.4 Community-based residential supports excluding assisted living;

3.4.10.9.2.2.5 Financial coaching;

3.4.10.9.2.2.6 IADL/chore (for DSHP Plus LTSS members, the Contractor is responsible for IADL/chore services that are Medically Necessary per the Contractor's UM guidelines (see Section 3.12 of this Contract)).

3.4.10.9.2.2.7 Individual employment supports;

necessary member information with PPECs consistent with State and Federal confidentiality and privacy requirements, and coordinating Covered Services and PPEC services.

3.8.9.4 Day Habilitation Services for Persons with Developmental Disabilities

3.8.9.4.1 The Contractor shall coordinate Covered Services and day habilitation services for members with developmental disabilities.

3.8.9.5 Non-Emergency Medical Transportation

3.8.9.5.1 The Contractor shall coordinate non-emergency medical transportation for members to ensure that members receive non-emergency medical transportation as needed. At a minimum, this shall include providing information to members on how to access non-emergency medical transportation, referring members to the State's non-emergency medical transportation vendor, and providing information and assistance as necessary to ensure that members receive appropriate transportation to Covered Services.

3.8.9.6 Specialized Services Not Included in Covered Services

3.8.9.6.1 The Contractor shall include all Specialized Services specified by the State as part of the Level II PASRR process in the member's plan of care, including Specialized Service that are not Covered Services, and shall coordinate with DSAMH and/or DDDS (as applicable) and nursing facilities to ensure that members receive Specialized Services specified by the State as part of the Level II PASRR that are not included in the DSHP or DSHP Plus LTSS benefit package.

3.8.9.7 Employment Services Provided through Pathways

3.8.9.7.1 If contacted by an employment navigator, the Contractor shall provide the name and contact information of the Contractor's point of contact for coordination of services, and the Contractor shall coordinate Covered Services and services provided through Pathways. See Section 3.7 of this Contract for coordination requirements specific to DSHP Plus LTSS members.

3.8.9.8 Chiropractic Services for Alternative Benefit Plan Members

3.8.9.8.1 The Contractor shall coordinate Covered Services and chiropractic services for members in the MAGI adult group.

3.8.9.9 Behavioral Health Services for Children

3.8.9.9.1 If a member under age 18 is determined, using a protocol provided by DPBHS of DSCYF, to require additional units beyond those included in the DSHP benefit package or more intensive services than the Contractor must provide as part of the DSHP benefit package, then the Contractor shall refer the member to DPBHS so that his/her behavioral health needs can be met. Should any disagreement arise concerning the referral, the dispute will be resolved by a committee that includes the Contractor's medical/clinical director and appropriate State staff as determined by the State.

3.8.9.10 Behavioral Health Services Provided to Adults through PROMISE

3.8.9.10.1 For DSHP and DSHP Plus members participating in PROMISE, DSAMH has primary responsibility for PROMISE eligibility determination and re-determination.

3.8.9.10.1.1 For members other than DSHP Plus LTSS members, DSAMH has primary responsibility for plan of care development, revision and monitoring, but the Contractor is responsible for coordination as specified below.

3.8.9.10.1.2 For DSHP Plus LTSS members participating in PROMISE, the Contractor shall have primary responsibility for plan of care development, revision and monitoring but shall involve the DSAMH care manager as specified in Section 3.7 of this Contract.

3.8.9.10.2 Upon determination that a member is eligible for PROMISE, DSAMH will notify the member of the decision. Additionally, DSAMH will inform the Contractor of the determination decision and provide the name and contact information of the assigned DSAMH care manager. The Contractor shall provide the DSAMH care manager with the name and contact information of the Contractor's point of contact for coordination of services to be provided by the Contractor.

3.8.9.10.3 The Contractor shall work with DSAMH to develop a collaboration protocol that includes strategies and activities to effectively communicate and coordinate care for members who are participating in PROMISE. The collaboration protocol, which shall be implemented as of the Start Date of Operations, shall include at a minimum:

3.8.9.10.3.1 How the Contractor will ensure its staff are adequately trained regarding the PROMISE program, including eligibility criteria, referral processes, services provided by PROMISE, the

services that are the responsibility of the Contractor (see Section 3.4 of this Contract), and coordination with the DSMAH care manager;

3.8.9.10.3.2 How the Contractor will ensure adequate resources and capacity to participate in service coordination with DSAMH for services provided by the Contractor, including when members are being discharged from an inpatient or residential behavioral health setting to a community placement;

3.8.9.10.3.3 How the Contractor's point of contact for collaboration and the member's DSAMH care manager will work together to develop, implement and update plans of care that address all of the member's needs and include all services to be provided by the Contractor and DSAMH; and

3.8.9.10.3.4 How the Contractor's point of contact for collaboration and the member's DSAMH care manager will work together to track and monitor implementation of the plans of care and member outcomes.

3.8.10 Coordination with Medicare

3.8.10.1 The Contractor shall accept Medicare data for its members and load the data into the Contractor's system for use by, at a minimum, case management, care coordination, member services, claims processing, and UM staff.

3.8.10.2 The Contractor shall be responsible for coordination of benefits with Medicare for members who are also enrolled in Medicare in accordance with the State's payment guidelines. See Section 3.18.3 of this Contract for Third Party Liability (TPL) requirements.

3.8.10.3 The Contractor shall provide Medically Necessary Covered Services to full benefit Dual Eligible members (members enrolled in both Medicare and Medicaid and entitled to full Medicaid benefits, not just Medicare cost sharing) if the service is not covered by Medicare.

3.8.10.4 The Contractor shall coordinate with Medicare payors, Medicare Advantage plans and Medicare providers as appropriate to coordinate the care of members who are also enrolled in Medicare.

3.8.11 Members with Special Health Care Needs (SHCN)

3.8.11.1 General

3.8.11.1.1 In accordance with 42 CFR 438.208(c)(2), the Contractor shall assess each member identified as having SHCN in order to identify

3.15.3.1.3.1 Who were not involved in any previous level of review or decision-making; and

3.15.3.1.3.2 Who, if deciding any of the following, are Health Care Professionals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:

3.15.3.1.3.2.1 An Appeal of a denial that is based on lack of Medical Necessity.

3.15.3.1.3.2.2 A Grievance regarding denial of expedited resolution of an Appeal.

3.15.3.1.3.2.3 A Grievance or Appeal that involves clinical issues.

3.15.3.2 The Contractor's process for Appeals must:

3.15.3.2.1 Provide that oral inquiries seeking to Appeal an Action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing by the member within 10 calendar days, unless the member or the provider requests expedited resolution.

3.15.3.2.2 Provide the member a reasonable opportunity to present evidence and allegations of fact or law, in person or telephonically as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.)

3.15.3.2.3 Provide the member and member representative opportunity, before and during the Appeals process, to examine the member's case file, including medical records considered during the Appeals process, and provide copies of documents contained therein without charge.

3.15.3.2.4 Provide to the State a copy of the member's case file, including medical records, within five business days of the State's request.

3.15.3.2.5 Include, as parties to the Appeal:

3.15.3.2.5.1 The member and member representative; or

3.15.3.2.5.2 The legal representative of a deceased member's estate.

3.15.3.2.6 Provide the member and member representative the opportunity to participate in the Appeal meeting in person or telephonically.

3.15.3.2.7 Ensure the Contractor's DSHP Member Advocate (for DSHP members) or DSHP Plus Member Advocate (for DSHP Plus

members) (see Section 3.20.2 of this Contract) participate in the Appeal process and support the member and member representative during the Appeal. If the member or member representative attends the Appeal meeting in person, the applicable member advocate shall attend the Appeal meeting in person.

3.15.3.2.8 Operate an Appeal committee that includes individuals who meet the requirements of Section 3.15.3.1.3 of this Contract, above. At a minimum the Appeal committee shall include as voting members one State staff person designated by the State, a physician employed by the Contractor, and the Contractor's QM/QI Coordinator or designee.

3.15.4 **Resolution and Notification: Grievance and Appeals**

3.15.4.1 The Contractor must dispose of each Grievance and resolve each Appeal, and provide notice, as expeditiously as the member's health condition requires, within timeframes that may not exceed the timeframes specified in this Section of the Contract.

3.15.4.2 For standard disposition of Grievance and notice to the affected parties, the timeframe shall not exceed 30 calendar days from the day the Contractor receives the Grievance.

3.15.4.3 For standard resolution of an Appeal and notice to the affected parties, the timeframe shall not exceed 45 calendar days from the day the Contractor receives the Appeal. This timeframe may be extended under Section 3.15.4.5 of this Contract, below.

3.15.4.4 For expedited resolution of an Appeal, the Contractor shall resolve the Appeal and notice the affected parties as expeditiously as the member's health condition requires, but no longer than three business days after the Contractor receives the Appeal. This timeframe may be extended under Section 3.15.4.5 of this Contract, below.

3.15.4.5 The Contractor may extend the timeframes for Sections 3.15.4.3 and 3.15.4.4 of this Contract, above, by up to 14 calendar days if:

3.15.4.5.1 The member requests the extension; or

3.15.4.5.2 The Contractor shows (to the satisfaction of the State, upon its request) that there is need for additional information and how the delay is in the member's interest.

3.15.4.6 If the Contractor extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

APPENDIX 1: CONTRACTOR RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES TO MEMBERS UNDER AGE 18

Contractor Responsibility within the 30 Units of Outpatient Behavioral Health Services for Members under Age 18

1. As specified in Section 3.4 of this Contract, the Contractor shall provide 30 outpatient units of behavioral health services per year for any member under age 18.

2. As part of the 30 outpatient units of behavioral health services, the Contractor shall provide the following five periodic outpatient services:

    a. Assessment – This service evaluates the child's behavioral health problem, establishes a valid DSM diagnosis and a treatment plan. In addition to assessments needed for treatment planning purposes, the Contractor must provide the required assessments to refer appropriate children to DSCYF for moderate or intensive services.

    b. Individual, Family and Group Therapy – Psychological counseling for the child, child's family, or significant others shall be appropriate and culturally responsive to the diverse needs of the individuals served.

    c. Crisis Intervention – If a family or clinician defines the member's behavioral health problem as an emergency requiring immediate response, the Contractor must be capable of seeing the child and family immediately in the family's home or other appropriate setting. This service must be available 24 hours a day, seven days a week.

    d. Intensive Outpatient – Some children in acute situations may avoid placement out of home if intensive treatment and supervision is provided for a brief period. This service also involves psychotherapeutic intervention in the family's home or other relevant environments.

    e. Rehabilitation Services – Services provided on an individual, family or group basis to enable children to remain in the home and to improve the family's capacity for self-sufficiency (i.e., functioning without DSCYF statutory intervention). Key functions include but are not limited to training and assistance in developing or maintaining skills such as conflict resolution, home management, stress management, healthy lifestyles, and education, training, and the family's role in management of the illness.

Contractor Responsibility Outside the 30 Units of Outpatient Behavioral Health Services for Members under Age 18

Certain behavioral health-related services and services to members under age 18 with behavioral health needs are Covered Services outside of the 30 units of outpatient behavioral health services. The Contractor shall provide these services as Medically Necessary and shall not count these services against the 30 units of outpatient behavioral health services. These services include, but are not limited to the following:

1. EPSDT screening, including specific behavioral health screening components.

2. All non-psychiatric treatment services provided in inpatient hospitals, regardless of the child's behavioral health diagnosis, for example, an anorexic adolescent with life-threatening weight loss.

3. All prescribed medications, including psychotropic, anti-depressant or other drugs used in behavioral health treatment.

4. Medication management, inpatient or outpatient, for all prescribed medications, including psychotropic, anti-depressant or other drugs used in behavioral health treatment.

5. Outpatient physician or pediatrician visits, including emergency room visits for medical and behavioral health reasons.

6. Medical detox services to adequately evaluate for appropriate triage and follow-up services.

7. Care coordination provided to link children and their families to needed medically-related services, and coordination with relevant agencies that provide those services; consultation with the child, family members, and family social network in the development of the child's integrated health and behavioral health treatment plan.

8. Coordination activities to ensure adequate continuity of care for a child between Contractor and DSCYF services, and coordination activities to ensure adequate and necessary primary health care provision for children in custody of DSCYF.

9. In general, both a diagnosis of behavioral health and an acceptable (agreed to by the State) procedure (or revenue) code must be provided to be considered part of the 30 units of outpatient behavioral health services for members under age 18.