COMMONWEALTH of VIRGINIA

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TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **August 15, 2013**

SUBJECT: **Fast Track Regulations - Early Intervention (Part C) Targeted Case Management (3535/6384)**

I am in receipt of the attached regulations regarding Early Intervention (Part C) Targeted Case Management (12 VAC 30-50-415, 12 VAC 30-80-110, and 12 VAC 30-120-380). You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations and if these regulations comport with state and federal law.

Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, and in consultation with the Department of Behavioral Health Developmental Services pursuant to Virginia Code § 2.2-5300 *et seq.*, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Pursuant to Va. Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the

normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

Because the promulgation of these regulations will amend the State Plan, approval by CMS will also be required. If you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esquire

Attachment

Project 2955 - Fast-Track

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Early Intervention (Part C) Case Management

12VAC30-50-415. Case management for Individuals Receiving Early Intervention (Part C) Services.

A. Target group for early intervention case management: Medicaid eligible children from birth up to age three years who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay who participate in the early intervention services system described in Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia.

B. Services are provided throughout the Commonwealth.

C. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the *Social Security Act* (the *Act*) is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the *Act*.

D. Definition of services: Early intervention case management services are services furnished to assist individuals eligible under the State Plan who reside in a community setting in gaining access to medical, social, educational, and other services. Early intervention case management includes the following assistance:

1. Comprehensive assessment and at least annual reassessment of individual needs to determine the need for any medical, educational, social, or other services, including EPSDT services.

2. Development and at least annual revision of an individualized family service plan (IFSP) as defined in coverage of Early Intervention Services under Part C of IDEA

(12VAC30-50-131) based on the information collected through the assessment. A face-to-face contact with the child's family is required for the initial development and revision of the IFSP. The case manager shall be responsible for determining if the family's particular situation warrants additional face-to-face visits.

3. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the IFSP.

4. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the IFSP is effectively implemented and adequately addresses the needs of the eligible individual. At a minimum one telephone, e-mail, or face-to-face contact shall be made with the child's family every three calendar months, or attempts of such contacts. This contact or attempted contact shall be documented. The case manager shall be responsible for determining if the family's particular situation warrants additional family contacts.

5. Early intervention case management includes contacts with family members, service providers, and other non-eligible individuals and entities who have direct knowledge of the eligible individuals' needs and care.

E. Qualifications of providers.

Individual providers providing early intervention case management must be certified as Early Intervention Case Managers by the Department of Behavioral Health and Developmental Services (DBHDS).

F. Freedom of choice.

The Commonwealth assures that the provision of case management services will not restrict an eligible individual's freedom of choice of providers.

1. Eligible recipients shall have free choice of the providers of early intervention case management services within the specified geographic area identified in this plan.

2. Eligible recipients shall have free choice of the providers of other medical care under the plan.

3. Providers of early intervention case management shall be limited to entities designated by the local lead agencies under contract with the Department of Behavioral Health and Developmental Services pursuant to § 2.2-5304.1 of the *Code of Virginia*.

G. Access to services. The Commonwealth assures the following:

1. Case management services shall be provided in a manner consistent with the best interest of recipients and shall not be used to restrict an individual's access to other Medicaid services.

2. Individuals shall not be compelled to receive case management services. The receipt of other Medicaid services shall not be a condition for the receipt of case management services, and the receipt of case management services shall not be a condition for receipt of other Medicaid services.

3. Providers of case management services do not exercise DMAS' authority to authorize or deny the provision of other Medicaid services.

H. Payment for early intervention case management services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case records.

Case management services shall be documented and maintained in individual case records in accordance with 42 CFR § 441.18(a)(7). Case records shall include:

1. The name of the individual;

2. The dates of the case management services;

3. The name of the provider agency and the person providing the case management services;

4. The nature, content, units of the case management services received and whether the goals specified in the care plan have been achieved;

5. Whether the individual has declined services in the care plan;

6. The need for, and occurrences of, coordination with other case managers;

7. A timeline for obtaining needed services; and

8. A timeline for reevaluation of the plan.

J. Limitations.

1. Early intervention case management shall not include the following:

a. Activities not consistent with the definition of case management services in 42 CFR § 440.169.

b. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

c. Activities integral to the administration of foster care programs.

d. Activities for which third parties are liable to pay, except for case management that is included in an IFSP consistent with § 1903(c) of the *Social Security Act*.

2. Providers shall not be reimbursed for case management services provided for these groups when these children also fall within the target group for early intervention case management as set out herein:

a. Seriously mentally ill adults and emotionally disturbed children (12VAC30-50-420);

b. Youth at risk of serious emotional disturbance (12VAC30-50-430);

c. Individuals with intellectual disability (12VAC30-50-440); or,

d. Individuals with intellectual disability and related conditions who are participants in the home-based and community-based care waivers for persons with intellectual disability and related conditions (12VAC30-50-450).

3. Case management shall be reimbursed only when all of the following conditions are met:

a. A least one documented case management service is furnished during the month; and

b. The provider is certified by DBHDS and enrolled with DMAS as an Early Intervention Case Management provider.

12VAC30-80-110. Fee-for-service: Case Management.

A. Targeted case management for high-risk pregnant women and infants up to age two, for community mental health and mental retardation services, and for individuals who have applied for or are participating in the Individual and Family Developmental Disability Support Waiver program (IFDDS Waiver) shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

B. Targeted case management for Early Intervention (Part C) children:

1. Targeted case management for children from birth to age three who have developmental delay who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of October 11, 2011, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management shall not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services, and intensive in-home services for children and adolescents.

3. Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12 VAC 30-50-410. Providers of early intervention case management shall coordinate services with providers of care management services for high risk infants, pursuant to 12 VAC 30-50-410, to ensure that services are not duplicated.

4. Each entity receiving payment for services as defined in 12 VAC 30-50-415 shall be required to furnish the following to DMAS, upon request:

a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and,

b. Cost information by practitioner.

5. Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of targeted case management through Post-Payment Review (PPR). PPRs ensure that paid services were rendered appropriately, in accordance with state and federal policies and program requirements, provided in a timely manner, and paid correctly.

12VAC30-120-380. Medallion II MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part.

1. Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the emergency departments.

2. Services that shall be provided outside the MCO network shall include, but are not limited to, those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include dental and orthodontic services for children up to age 21; for all others, dental services (as described in 12VAC30-50-190), school health services (as defined in 12VAC30-120-360), community mental health services (rehabilitative, targeted case management and the following substance abuse treatment services; emergency services (crisis); intensive outpatient services; day treatment services; substance abuse case management services; and opioid treatment services), as defined in 12VAC30-50-228 and 12VAC30-50-491, EPSDT Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 (as defined in ~~12VAC30-50-131)~~ 12VAC30-50-131 and 12VAC30-50-415), and long-term care services provided under the § 1915(c) home-based and community-based waivers including related transportation to such authorized waiver services.

3. The MCOs shall pay for emergency services and family planning services and supplies whether they are provided inside or outside the MCO network.

B. Except for those services specifically carved out in subsection A of this section, EPSDT services shall be covered by the MCO and defined by the contract between DMAS and the MCO. The MCO shall have the authority to determine the provider of service for EPSDT screenings.

C. The MCOs shall report data to DMAS under the contract requirements, which may include data reports, report cards for clients, and ad hoc quality studies performed by the MCO or third parties.

D. Documentation requirements.

1. The MCO shall maintain records as required by federal and state law and regulation and by DMAS policy. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

2. Each MCO shall have written policies regarding enrollee rights and shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees in accordance with 42 CFR 438.100.

E. The MCO shall ensure that the health care provided to its clients meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

F. The MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the state and the contractor. Medical evaluations shall be available within 48 hours for urgent care and within 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

G. The MCOs must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor.

H. Each MCO and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

I. In accordance with 42 CFR 447.50 through 42 CFR 447.60, MCOs shall not impose any cost sharing obligations on enrollees except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his patient in accordance with 42 CFR 438.102.

K. An MCO that would otherwise be required to reimburse for or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR 438.102.