Virginia Regulatory Town Hall

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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-50 and 12 VAC 30-60
Regulation title	Amount, Duration, and Scope of Services for Categorically Needy and Medically Needy Individuals; Standards Established and Methods Used to Assure High Quality of Care
Action title	Mental Health Support Services
Date this document prepared	

This form is used when an agency wishes to promulgate an emergency regulation (to be effective for up to one year), as well as publish a Notice of Intended Regulatory Action (NOIRA) to begin the process of promulgating a permanent replacement regulation.

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Preamble

The APA (Code of Virginia § 2.2-4011) states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of subdivision A. 4. of § 2.2-4006.

1) Please explain why this is an emergency situation as described above.
2) Summarize the key provisions of the new regulation or substantive changes to an existing regulation.

Section 2.2-4011 of the *Code of Virginia* states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006(A)(4). The 2012 *Acts of the Assembly*, Chapter 3, Item 307 LL directed the agency to make programmatic changes in the provision of Community Mental Health services in order to ensure appropriate utilization and cost efficiency.

The Governor is hereby requested to approve this agency's adoption of the emergency regulations entitled Mental Health Support Services (12 VAC 30-50-226 and 12 VAC 30-60-143) and also authorize the initiation of the promulgation process provided for in § 2.2-4007.01 *et seq*.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority. [Please cite the authority you are using to promulgate an emergency regulation.]

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324 and 325, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

In addition, § 2.2-4011 of the *Code of Virginia* states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of subdivision A. 4. of § 2.2-4006.

The 2012 *Acts of the Assembly*, Chapter 3, Item 307 LL directed DMAS to make programmatic changes in Community Mental Health Services and to consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. DMAS was directed to promulgate regulations to implement these changes.

Pursuant to the 2012 *Acts of Assembly,* Chapter 3, Item 307 RR (f) directed DMAS to implement a mandatory care coordination model for Behavioral Health. The goals of Item 307 RR (e) include the achievement of cost savings and simplification of the administration of Community Mental Health Services through the use of the Behavioral Health Services Administrator. Item 307 RR (f) authorizes DMAS to promulgate emergency regulations for this mandatory model.

Purpose

Please describe the subject matter and intent of the planned regulatory action. Also include a brief explanation of the need for and the goals of the new or amended regulation.

The Medicaid covered service that is affected by this action is Mental Health Support Services (MHSS). DMAS always intended it to have a rehabilitative focus and defined it as training and supports to enable individuals to achieve and maintain stability and independence in their communities. The application of imprecise eligibility criteria and service definitions has resulted in providers misunderstanding of DMAS' intent and of the slow evolution of MHSS into a companion-like service rather than rehabilitation. This has contributed to the $138 M increase in expend-

itures for this service. Most of this expenditure increase has been attributed to adult Medicaid individuals.

DMAS intends, in this action, to more accurately discuss the agency's intentions for this service by clarifying the Medicaid individuals' eligibility criteria, service definitions, and reimbursement requirements.

Need

Please detail the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, delineate any potential issues that may need to be addressed as the regulation is developed.

MHSS is being inappropriately utilized as evidenced by reports from DBHDS' licensing specialists and DMAS' auditors. Individuals who have been receiving the services are not measurably improving and this service is costing the Commonwealth millions of dollars. The new limitations will help prevent overpayments for similar services, will improve the quality of services covered, and will clarify for service providers this agency's expectations in order to secure reimbursement. These changes seek to preserve the integrity of the Medicaid system, so that it can continue to provide necessary medical services to appropriate individuals.

Substance

Please detail any changes that will be proposed. Please outline new substantive provisions, all substantive changes to existing sections, or both where appropriate.

The sections of the State Plan for Medical Assistance that are affected by this action are: the Amount, Duration, and Scope of Services (12 VAC 30-50-226) and Standards Established and Methods Used to Assure High Quality of Care (12 VAC 30-60-143).

Currently, Chapter 50 sets out the coverage limits for Community Mental Health Services which includes therapeutic day treatment (TDT)/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT) and mental health support services.

CURRENT POLICY

At the present time, Mental Health Support Services (MHSS) is a Medicaid community mental health treatment service with a rehabilitative focus and defined as training and supports to enable individuals to achieve and maintain stability and independence in their communities in the most appropriate, least restrictive environments. Currently, MHSS includes the following services:

- Training in or reinforcement of functional skills and appropriate behavior related to the individuals' health and safety, conduct of activities of daily living, and use of community resources in pursuit of successfully adjusted lives;
- Assistance with medication management; and
- Monitoring health, nutrition, and physical conditions.

ISSUES

Imprecise Medicaid eligibility criteria and service definitions have allowed individuals who do not have a serious mental illness or a serious emotional disturbance to access Medicaid's MHSS. DBHDS' licensing specialists and DMAS' auditors report that MHSS services have become more like companion care and less like mental health training with a rehabilitative and maintenance focus.

DMAS believes that the use of the term 'and supports' in this service definition has contributed to providers' misunderstanding the purpose of this service which has contributed to the $138 M increase in expenditures. Most of this increase has been attributable to adult Medicaid individuals.

RECOMMENDATIONS

The intent of this service has always been to provide training to individuals, who have severe, chronic mental illness or emotional disturbances, so that they can successfully and independently live in their communities in the least restrictive environments possible. To resolve the discrepancy between the intent of the service and the way in which it is provided, DMAS is changing the service's name to Mental Health Skill-building Service to emphasize the rehabilitative nature of the service.

The suggested changes contained herein seek to significantly strengthen the eligibility criteria for MHSS, more accurately define/rename the service, to ensure that only individuals who clinically qualify for the service actually receive it. The regulations also change the rate structure to an hourly unit and decrease the number of hours per day that an individual may receive the service (decreasing from seven hours to up to 5.0 hours) to ensure that the service is not over-utilized. This change is being implemented July 1, 2014, due to the logistics of putting in place the new billing unit and service limitation systems.

In the past, providers were permitted to bill seven hours of service per day but the annual limit of 372 units per year was quite low. This created an imbalance, such that if an individual continued to need this long-term service over the course of a year, he would reach his annual limit well before the end of the year. (The annual limit of 372 units actually only allowed approximately one unit to be provided per day.) The changes in the daily, weekly, and annual limits align services so that they may be provided consistently over the course of a year. This change also implements July 1, 2014.

The regulations also prohibit overlaps of MHSS with other similar services which are duplicative and not therapeutically beneficial. For example, MHSS will no longer be available to individuals who are receiving in-home residential services or congregate residential services provided through the Intellectual Disability or Individual and Family Developmental Disability Support home and community based waivers.

Similarly, MHSS will no longer be available to individuals who are receiving Treatment Foster Care or independent living services through programs offered by the Department of Social Services or the Office of Comprehensive Services. Any overlap in these services with MHSS is considered duplicative and clinically ineffective.

The regulations also reduce the number of hours of MHSS that may be provided in an assisted living facility and Level A or Level B group homes to ensure that the service is not duplicative of services that are already being provided in residential placements, such as assistance with medication management. The regulations require that providers offer half of each week's MHSS hours to residents of ALFs or group homes outside of their residential setting to assist with training that will enable these individuals to achieve and maintain community stability and independences. The regulations also specify that MHSS may not be provided to residents of Intermediate Care Facilities for the Intellectually Disabled or hospitals to prohibit inappropriate overlaps of MHSS with these providers.

MHSS are herein being provided to NF residents, who are being discharged, during the last 60 days of the nursing facility stay. The service may be reauthorized for another 60 days only if discharge to the community is planned. This allows individuals to access MHSS to transition from a nursing facility into an independent living arrangement. This new limitation also prevents individuals, remaining in a nursing facility on a long-term basis, from accessing MHSS since they do not require training in community independent living skills.

Similarly, in order for individuals in residential treatment facilities to transfer to the community, the MHSS assessment may be performed in the last seven days before discharge. This allows MHSS services to begin as soon as the individual is discharged into the community.

The regulations also seek to improve the quality of the services provided by ensuring that MHSS providers communicate important information to other healthcare professionals who are providing care to the same individuals. In the past, there has been very little communication with other health care practitioners, and virtually no communication with prescribing physicians. These regulatory changes seek to address this gap. For example, if an individual who receives MHSS under the new criteria fails to adhere to his prescribed medication regimen, it could have a significant, negative impact on the individual's mental health. If a paraprofessional providing MHSS to an individual learns of the non-adherence to the prescribed medication regimen, he is now being required in these regulations to notify his or her supervisory staff of the individual's medication issues. Supervisory staff are also being required to communicate this information to the individual's treating physician, so that he or she is aware of the problem and therefore is enabled to address it at the next visit.

Further, as providers have adjusted to recent regulatory requirements implemented by DMAS (including an independent assessment for individuals under the age of 21), they have begun to expand their businesses into other services that they may be able to provide. As a result, there has been significant growth in the two crisis services offered in the community – Crisis Intervention and Crisis Stabilization. These services were the only two community mental health services that, to date, have been exempt from service authorization. DMAS is now seeking to require service authorization for them. DMAS believes this step is necessary to preserve the integrity and quality of this service by ensuring that only individuals who are truly in crisis receive these services. DMAS is ensuring that service authorization does not delay or prevent services to those individuals who are in crisis, by requiring providers to request authorization within a period of time after initiating services.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, and likely impact of proposed requirements
12 VAC 30-50-226		Mental health support services are established and defined.	In order to qualify for this service, an individual must have a recent qualifying Axis I DSM diagnosis, a prior history of psychiatric hospitalization, etc., and have a prescription for required psychiatric medications. Changed billing units and service limits.
12VAC 30-50-226		Behavioral Health Services Administrator defined.	Added definition of Behavioral Health Services Administrator (BHSA) to clarify the authority to oversee a provider network for the provision of Medicaid-covered behavioral health services.
12 VAC 30-60-143		Utilization control requirements for mental health support services.	Providers must document the required diagnosis; this service cannot be rendered simultaneously with other specified State Plan and waiver services; this service cannot duplicate other services. Changed service limits.

Alternatives

Please describe all viable alternatives to the proposed regulatory action that have been or will be considered to meet the essential purpose of the action. Also describe the process by which the agency has considered or will consider, other alternatives for achieving the need in the most cost-effective manner.

DMAS considered implementing the Independent Clinical Assessment (ICA) for adult recipients of MHSS. (Children and youth who receive MHSS already must receive an ICA.) However, it was determined that without revisions to eligibility criteria for the MHSS program, the ICA would not be as effective as desired in curbing inappropriate utilization. Therefore, DMAS determined that it would pursue the eligibility changes and that if they are not effective (as measured by utilization trends and spending amounts), it will add an ICA requirement (through a regulatory change) in the future.

Public participation

Please indicate the agency is seeking comments on the intended regulatory action, to include ideas to assist the agency in the development of the proposal and the costs and benefits of the alternatives stated in this notice or other alternatives. Also, indicate whether a public meeting is to be held to receive comments on this notice.

Please also indicate, pursuant to your Public Participation Guidelines, whether a panel has been used in the development of the emergency regulation and whether it will also be used in the development of the proposed regulation.

The agency is seeking comments on the regulation that will permanently replace this emergency regulation, including but not limited to 1) ideas to be considered in the development of the per-

manent replacement regulation, 2) the costs and benefits of the alternatives stated in this background document or other alternatives and 3) the potential impacts of the regulation.

The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) the probable effect of the regulation on affected small businesses, and 3) the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (**http://www.townhall.virginia.gov**), or by mail, email, or fax to Sandra Brown, Manager, Office of Behavioral Health Services, DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219; (804) 786-0102; (804) 786-1680; Sandra.Brown@dmas.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Family impact

Assess the potential impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.