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# Proposed Regulation
# Agency Background Document

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| **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 Skill-building Services |
| **Date this document prepared** | |

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.*

## Brief summary

*In a short paragraph, please summarize all substantive provisions of new regulations or changes to existing regulations that are being proposed in this regulatory action.*

DMAS is proposing to re-name and re-define the currently covered Mental Health Support Services to Mental Health Skill-building Services (MHSS) in order to emphasize the rehabilitative nature that DMAS always intended for this service to have. This service was never intended to be interpreted as long-term companion care, or community social assistance. DMAS is also proposing specific criteria that individuals must meet in order to be approved to receive this service. The changes were made in collaboration with the Department of Behavioral Health and Developmental Services, Virginia Board for People with Disabilities, the Virginia Association of Community Services Boards, Virginia Alliance for Mentally Ill, Virginia Coalition of Private Provider Associations, Private Mental Health agencies such as Family Preservation Services, Family Focus, National Counseling Group and St. Joseph's Villa. Stakeholder meetings were held during 2012 and in February, 2014.

DMAS is establishing the use of its behavioral health services administration contractor.

Adults (individuals 21 years of age and older) must: (i) have at least one of several listed DSM diagnoses; (ii) shall require individualized training in basic community living skills in order to successfully remain independent in the community; (iii) have a prior history of psychiatric illnesses that required institutionalization or have a history of certain behavioral health treatment, and; (iv) shall have had a prescription for psychotropic medications.

Young people (individuals younger than 21 years of age) must: (i) have at least one of the several listed DSM diagnoses; (ii) shall require individualized training in basic community living skills in order to successfully live in the community; (iii) have a prior history of psychiatric illnesses that required institutionalization or have a history of certain behavioral health treatment; (iv) shall have had a prescription for psychotropic medications; (v) be living independently or actively transitioning (within 6 months) to independent living; (vi) have had completed for them an Independent Clinical Assessment (known as VICAP).

DMAS proposes to establish service-provision and documentation criteria that must be met in order for providers to be authorized to render this service and be paid. Adhering to these new documentation standards may enable providers to be more successful in their provider audits. Failing such audits results in provider repayments to DMAS of funds received. DMAS is also proposing to clarify provider qualifications to ensure that appropriately trained/licensed professionals are caring for these individuals with serious mental illness. When care is rendered by inadequately trained or non-licensed professionals, great harm can be created to these individuals.

DMAS proposes to establish service authorization requirements for the two crisis services (intervention and stabilization) already covered under the authority of 12 VAC 30-50-226. The purpose of this proposal is to stabilize rapidly increasing expenditures as documented for DMAS' existing Mental Health Support Services.

These proposed regulations are substantially consistent in their definitions, criteria and requirements with the previous emergency regulation stage.

## 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.*

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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.

The 2012 *Acts of the Assembly*, Chapter 3, Item 307 LL directed DMAS to make programmatic changes in Community Mental Health Rehabilitative 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. In response, DMAS promulgated emergency regulations for this issue.

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 Services. The goals of Item 307 RR (e) include the achievement of cost savings and simplification of the administration of Community Mental Health Rehabilitative Services through the use of the Behavioral Health Services Administrator. Item 307 RR (f) authorizes DMAS to promulgate emergency regulations for this mandatory model.

Pursuant to the *2013 Acts of Assembly*, Chapter 806, Item 307 DD, DMAS was directed to implement service authorization and utilization review for community-based mental health rehabilitative services for children and adults. Mental health skill-building services is one of the included services.

## Purpose

*Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal, the environmental benefits, and the problems the proposal is intended to solve.*

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The Medicaid covered service that is affected by this action is Mental Health Support Services (MHSS), renamed Mental Health Skill-building Services to better reflect the intent of the service. DMAS always intended this service 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 services other than rehabilitation. This has contributed to the $138 M increase in expenditures for this service. Most of this expenditure increase has been attributed to adult Medicaid individuals. Although this service was not intended to be a stand-alone service, but rather to be coupled with other services that the target population would most likely benefit from, it has been used to provide a wide variety of interventions. Stakeholders note that this service has been used to provide crisis intervention, counseling/therapy, transportation, recreation, and of significant concern, companion-like services, and general supervision.

DMAS' goal is that individuals receive the correct level of service at the correct time for the treatment (service) needs related to the individual's medical/psychiatric condition. Community mental health rehabilitative services (CMHRS) are behavioral health interventions in nature and are intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional disturbances. Clinical treatment differs from community social assistance and/or child welfare programs in that behavioral health services are designed to provide treatment to a mental illness rather than offer assistance for

hardship due to socio-economic conditions, age, or physical disability. Stakeholders' feedback supported and DMAS' observations concluded, without clarifying the service definition and eligibility requirements, that MHSS would continue its evolution into a social service level of support rather than remain a psychiatric treatment modality.

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.

## Substance

*Please briefly identify and explain new substantive provisions (for new regulations), substantive changes to existing sections or both where appropriate. (More detail about all provisions or changes is requested in the "Detail of changes" section.)*

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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 (section 226) sets out the coverage limits for Community Mental Health Rehabilitative 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 goal-directed training 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 components:

- Training in or reinforcement of functional skills and appropriate behavior related to the individuals' health and safety, training in the performance of activities of daily living, and use of community resources;
- Training about medication management; and
- Self-Monitoring of health, nutrition, and physical conditions.

ISSUES

Imprecise Medicaid eligibility criteria and service definitions have allowed individuals who have not been diagnosed with either a serious mental illness or 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 skills training with a rehabilitative and maintenance focus.

Community mental health rehabilitative services (CMHRS) are behavioral health interventions. They are intended to provide clinical treatment to those individuals with significant mental illness or children either with, or at risk of developing, serious emotional disturbances. Clinical treatment differs from community social assistance and/or child welfare programs in that behavioral health services are designed to provide treatment to a mental illness rather than assisting with hardships due to socio-economic conditions, age, or physical disabilities. Stakeholders' feedback and DMAS observations concluded that without clarifying the service definition and eligibility requirements, MHSS would continue to evolve into a social service level of support rather than a psychiatric treatment service.

Based on public comments during the NOIRA comment period, DMAS believes that some providers have billed this service for reimbursement when the service actually rendered involved driving the Medicaid individual to medical appointments (sometimes over long distances) and remaining with the individual to later return him home. Neither transportation nor companion services were ever intended to be covered as part of Mental Health Support Services. If a MHSS provider is transporting an individual, the provider may only bill for MHSS if skill-building training takes place for the entire time. Direct time spent with the individual is billable to DMAS as long as training in skills related to resolving functional limitations deriving directly from mental illness occurs during the entire time that is billed. Medicaid already provides transportation to medical appointments via its Logisticare contract.

DMAS believes that the use of the term 'and supports' in this original service definition has contributed to providers' misunderstanding this service which has contributed to the 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 help resolve the discrepancy between the intent of the service and the way in which it is currently being 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 also seek to significantly strengthen the service eligibility criteria for MHSS. By clarifying the service definition, DMAS anticipates that individuals who previously received non-skill building interventions via this service, will now more appropriately be directed to resources that can meet those non-skill-building needs; i.e., social services, crisis intervention, case management, etc.

Because this service may be provided by qualified mental health paraprofessionals and is training focused, DMAS has adjusted the rate structure. The regulations also change the rate structure to a 15 minute billing unit and decrease the number of units per day that an individual may receive the service (decreasing from seven hours to up to 5.0 hours allowable as a maximum of twenty 15 minute billing units per day) 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 computer systems.

In the past, providers were permitted to bill seven or more 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 service over the course of a year, he would reach his annual limit well before the end of the year. The current annual limit of 372 units yields approximately one unit per day. However, the daily billing allowance is up to four billing units per day with varying time values per unit billed. The current unit value is able to allow services in hourly ranges such as 1-2.99 hours and 3-4.99, 5-6.99 and 7+ hours per unit which creates an incentive to bill for more time than provided because of the imprecise unit value. The new unit value and new unit allowance would yield a maximum of 5 hours per day, 5 days per week for a total of 5,200 fifteen minute units per year. 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 that would be duplicative and not therapeutically beneficial. For example, MHSS will no longer be available to individuals who are also 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. This change is recommended to ensure that MHSS is not duplicative of services that are already being provided in residential placements, such as assistance with medication management. The regulations propose that providers offer half of each week's authorized MHSS hours to ALF/group home residents outside of their residential setting. This new requirement is intended to assist with training these individuals to achieve and maintain community stability and independence. The regulations also specify that MHSS may not be provided to residents of Intermediate Care Facilities for Individuals with Intellectual Disability or hospitals to prohibit inappropriate overlaps of MHSS with these providers.

MHSS may be provided to nursing facility residents who are being discharged, but only during the last 60 days of the nursing facility stay. The service may be reauthorized once for another 60 days only if discharge to the community is being developed. 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 their communities, the MHSS assessment may be performed in the last seven days before discharge allowing service onset upon discharge.

The regulations 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 bridge 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 required in these regulations to notify his or her supervisory staff of the individual's medication issues. Supervisory staff is 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 clinical assessment for individuals under the age of 21), they have begun to expand their businesses into other service areas that they may be able to provide. As a result, there has been significant expenditure growth in the two crisis services offered in the community – Crisis Intervention and Crisis Stabilization. These services are the only two community mental health rehabilitative 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 truly are in crisis by permitting providers to request authorization within a brief period of time after initiating services.

## Issues

*Please identify the issues associated with the proposed regulatory action, including:*
*1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;*
*2) the primary advantages and disadvantages to the agency or the Commonwealth; and*
*3) other pertinent matters of interest to the regulated community, government officials, and the public.*

*If the regulatory action poses no disadvantages to the public or the Commonwealth, please indicate.*

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The primary advantage to the Commonwealth for these changes, aside from reduced expenditures for MHSS, is that the individuals receiving these services will make functional gains and achieve enhanced tenure in their communities.

Individual private citizens will neither benefit nor be harmed by these recommended changes.

The Medicaid individuals who have become accustomed to the previous services from providers may feel harmed by the clearer criteria and change in service limits as they may not now qualify for these re-defined services or as much of the service as they had been getting. However,

responsible providers are expected to refer these individuals to more appropriate community resources. Providers allege that the rate and reimbursement changes will cause them business harm.

Efforts were made so the rate and unit changes would be budget neutral. It was learned during this process that some providers were using the funding for this service to pay for other non-Medicaid services which suggests a misalignment of the billing structure and delivery of the service. The restructured reimbursement allows compensation for all Medicaid-covered care that is delivered.

Local human service agencies may see an increase in referrals as former MHSS individuals seek to have their social service-related needs met which have been previously inappropriately addressed by MHSS providers.

## Requirements more restrictive than federal

*Please identify and describe any requirements of the proposal, which are more restrictive than applicable federal requirements. Include a rationale for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.*

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The Centers for Medicare and Medicaid Services do not set any service standards for the services affected by this action.

## Localities particularly affected

*Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.*

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No localities are uniquely affected by these recommended regulatory changes as these policies will uniformly apply statewide.

## Public participation

*Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.*

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In addition to any other comments, the board/agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is 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) probable effect of the regulation on affected small businesses, and

3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

DMAS' ad hoc advisory committee is listed in the attached exhibit.

Anyone wishing to submit written 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, Div. of Behavioral Health, DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219; Sandra.Brown@dmas.virginia.gov (804/786-0102; 804/786-1680 fax). 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 date of the public comment period.

## Economic impact

*Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact. Please keep in mind that we are looking at the impact of the proposed changes to the status quo.*

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| **Description of the individuals, businesses or other entities likely to be affected (positively or negatively) by this regulatory proposal.** Think broadly, e.g., these entities may or may not be regulated by this board | Medicaid Mental Health Support Service providers include both public and private providers. |
| **Agency's best estimate of the number of (1) entities that will be affected, including (2) small businesses affected.** Small business means a business, including affiliates, that is independently owned and operated, employs fewer than 500 full-time employees, or has gross annual sales of less than $6 million. | DMAS does not retain records about its providers concerning whether or not they meet the definition of a small business. Per DBHDS Office of Licensing, there were 265 MH Support providers as of July 2013 in 464 locations. |
| **Benefits expected as a result of this regulatory proposal.** | The regulations are intended to ensure that individuals with Medicaid receive the most clinically appropriate Medicaid mental health service. Medical record reviews have indicated that there is a wide variety of activity being provided under this service but very little actual training in order to assist individuals to increase their ability to live independently in their communities. DMAS anticipates that individuals who no longer qualify for this service will be re-directed to more appropriate services and resources. Individuals who do qualify for this service are expected to increase their ability to self-monitor, function more independently and decrease their reliance on |

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| | caretakers whether they be family, providers or other community members. DMAS expects that these regulations may decrease utilization of MHSS. |
| **Projected cost to the state to implement and enforce this regulatory proposal.** | DMAS expects that these regulations may decrease utilization of MHSS but may increase costs in outpatient and medication management related services. |
| **Projected cost to localities to implement and enforce this regulatory proposal.** | It may increase referrals to local DSS offices for social assistance. |
| **All projected costs of this regulatory proposal for affected individuals, businesses, or other entities.** Please be specific and include all costs, including projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses, and costs related to real estate development. | It was learned during this process that some providers were using the funding for this service to pay for other non-Medicaid services which suggests a misalignment of the billing structure and delivery of the service. The restructured reimbursement allows compensation for all care delivered. |

## Alternatives

*Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.*

DMAS could recommend that these community mental health services be entirely ended since they are not federally mandated services. However, to do so may increase inpatient psychiatric hospitalizations which are substantially more expensive or it could cause providers to inappropriately shift these individuals to other Medicaid services. This would foster the original issue of individuals being provided the wrong service. If MHSS were ended, it would also transfer the burden of caring for these individuals to the localities, through the local community services boards (CSBs), which are currently funded with General Fund (via DBHDS) and local dollars. Retaining these services as Medicaid covered enables the benefit of claiming 50% federal matching dollars, thereby reducing the demand for General Fund and local contributions.

DMAS could recommend that MHSS be returned to the previous eligibility criteria, service limits, and provider standards but this would result in a return to rapidly increasing costs. Just as importantly, the individuals receiving these services, under the former regulations, would be maintained at their current functioning level with minimal interventions to assist them in gaining true community integration and more independent lives like other citizens of the Commonwealth.

## Regulatory flexibility analysis

*Pursuant to §2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.*

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Small businesses cannot be exempted from these regulatory requirements as this is not permitted under Title XIX of the *Social Security Act*. These requirements set out DMAS' requirements for the coverage of this service which must be uniformly applied without regard for the size of the provider business. Small businesses are not required by DMAS to render this service or even be Medicaid-enrolled providers. DMAS does not require small businesses to submit reports in order to be reimbursed for providing this service. DMAS is required by federal law, 42 CFR § 430.960, to establish its criteria specific to the service being covered and not tied to the size of the provider rendering it. DMAS does not retain provider records which indicate which providers meet the small business standard.

## Public comment

*Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.*

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DMAS' Notice of Intended Regulatory Action was published in the *Virginia Register* dated November 4, 2013 (VR 30:5), for its comment period from November 4, 2013, through December 11, 2013. DMAS received comments from 24 individuals, 43 professionals in the human services field, and representatives from these organizations or companies: Creative Family Solutions, Mount Rogers Community Services Board, Fairfax Falls Church Community Services Board, Roanoke City Council, Center for Health and Human Development, NATASHA House, Inc, Hall Community Service, Inc., Child and Family Council of VACSB, In Home Clinical and Casework Services, Roanoke County Police, Behavioral Health Quality Management Consulting, Trinity Support Services HHRSCLLC, disability Law Center of Virginia, MHSS Agency Roanoke, MHNN CSB, Alleghany Highlands CSB. DMAS' summary of the points provided during this comment period is as follows:

| Comment | Agency response |
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| 1. Overall, the commenters disagreed with the changes in DMAS' current emergency regulations for Mental Health Skill-building Services (MHSS). Funding for mental health services should be increased not decreas-ed. Limiting community based services to individuals will only increase recidivism of psychiatric hospitalization and incarceration, which are far more costly to the State than preventive services. The scope of the | 1. Changes are not related to a decrease in funding for mental health services. Regulations do not limit community based services but more clearly re-define who is eligible for Mental Health Skill-building Services. Other one-on-one services are available to individuals with mental illness including Targeted Case Management, outpatient therapy, and other human service programs and entities which have been designed to assist individuals with decreasing mental health symptoms and/or assist with accessing community resources in order |

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| program has grown because there are no other long term one-on-one services for mentally ill adults which provide sufficient support. | to reduce psychiatric hospitalization and incarceration due to mental illness.<br><br>Changes in the regulations more clearly define MHSS as a rehabilitative program meant to increase community integration and thus community tenure by training individuals on functional skills. It was never intended as a supportive service (companion, recreation, general supervision).Community Mental Health Rehabilitative Services programs are rehabilitative in nature not a passive support. It was also not intended to be a stand alone service.<br><br>Unjustified growth in this service caused DMAS, the Administration and the General Assembly to review and address the increase in expenditures. Efforts were made so the rate and unit changes would be budget neutral. It was learned during this process that some providers were using the funding for this service to pay for other non-Medicaid services which suggests a misalignment of the billing structure and delivery of the service. The restructured reimbursement allows compensation for all care delivered. . |
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| 2. The changes will unfairly limit services and shut out Medicaid individuals who could be helped by the service. The criteria are being changed to save money and making it nearly impossible for young people to access the service. | 2. Services are rehabilitative in nature and intended to assist individuals who do not have the functional skills to maintain their health and safety independently in the community and to learn the skills necessary to do so. The criteria continue to allow for individuals under the age of 21 to receive services as long as they intend to transition into an independent living situation within six months. The service definition is being more clearly defined to distinguish this service from other service options and community resources. Clarifying the service definition should allow providers to better determine the correct level of service an individual needs and not try to use MHSS to meet needs the service is not designed to address. With the implementation of the Behavioral Health Services Administrator (BHSA-Magellan contract), providers will have a single point of contact to discuss care coordination needs, service options, and to some degree receive clinical review and consultation. |
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| 3. Requiring that individuals have a diagnostic history of mental illness or a record of psychotropic medications dooms borderline people with becoming mentally ill. | 3. This implies that Mental Health Support Services are preventive services. This is not accurate as this service, by falling under the criteria of 42 CFR 440.130(d), is rehabilitative in nature. 'Rehabilitative services …… includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts……..for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.' Individuals with mild to moderate mental health concerns may access other more appropriate services, such as outpatient therapy and medication, in order to prevent the escalation of symptoms to a more serious mental illness. |

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| | Community MH Rehabilitation Services were originally designed to address mental health needs of individuals who met the DBHDS definition of serious mental illness (SMI). That target population was being served nearly solely by the public providers, CSBs. Those individuals, deemed as SMI, have such significant mental illnesses that companion-like, recreational, or general supervision services do not increase their ability to care for themselves or their living setting or increase integration into their communities. MHSS was not intended to be a stand alone service, but rather to be coupled with medication management and case management; those 2 services primarily assist with helping individuals with SMI remain in the community without hospitalization and incarceration. The intent of the service was to serve individuals with significant needs and not individuals with marginal needs. |
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| 4. Many individuals who have mental illness choose to manage their disabilities without the use of prescribed medications. There are many options to manage mental illness; medication is just one. | 4. The regulations do not require individuals to take psychiatric medication. They require that a prescription for medication be written within the 12 months prior to the initial request for services. The purpose of the psychiatric evaluation is ensure that the individual has had the option to consider using medications and to have been educated about the benefits and risks of medication. Coupled with the other eligibility requirements, having the history of a prescription helps to reflect that the individual does indeed have a significant and chronic illness. |
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| 5. More individuals are going to end up incarcerated or hospitalized when they can no longer receive these services. | 5. Implies that Mental Health Support Services are preventive services. This is not accurate. See further response to number 3 above. With the implementation of the Behavioral Health Services Administrator (BHSA-Magellan contract), providers will have a single point of contact to discuss care coordination needs, service options, and to some degree clinical review and consultation. |
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| 6. Record documentation is difficult or impossible to obtain because state hospitals have closed or individuals refuse to report medication usage. | 6. In situations in which a hospital has closed, the clearly documented comprehensive effort of the provider to confirm the prior hospitalization will be accepted as meeting criteria. Mental Health Skill-building services are intended as a training and rehabilitative service. Proper care coordination in order to provide the most effective services for individuals requiring training in functional skills requires the coordination of care between service providers. History of a hospitalization is just one element of one of the components of eligibility.<br><br>Individuals who do not wish to disclose psychiatric medication usage to a mental health provider would most likely not be willing to disclose enough information to assist in the development of an individualized service plan |

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| | that would meet the intended goal of increasing functional skills; a higher level of service may be necessary. Providers must use some level of clinical judgment to determine whether an individual is psychiatrically stable enough to actively participate in and benefit from training in activities of daily living or social skills training. |
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| 7. If the previous regulations had been enforced, then spending for this service would not have gotten out of control. The control mechanisms in the previous regulations were adequate to control costs. | 7. Vague eligibility requirements and use as a general support service rather than a rehabilitative service resulted in increased spending. Previous eligibility requirements allowed for individuals without a significant mental health diagnosis to receive services in order to assist with housing and general supervision, for example. DMAS conducts periodic utilization review audits on all programs as mandated by Title 42 Part 455 and 456. It was also based on utilization review audit results and feedback from DBHDS Office of Licensing that DMAS concluded the services were being not provided as the service required. |
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| 8. Many individuals have been able to avoid the need for more intensive services, homelessness, incarceration, hospitalization due to Mental Health Support Services. | 8. Other less intensive services are available to individuals with mental illness to assist with housing and decrease symptoms in order to remain stable in the community. See further response to number 3 above. |
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| 9. Solution is increased oversight, increased auditing, enforcement of existing regulations with fines and obligations to pay back misappropriated funds. | 9. See response to number 7 above. |
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| 10. Sharing clients' information with their primary care physician violates Human Rights. Releasing clients' medical information by phone violates HIPAA. | 10. Exchanging client information among providers are currently part of the provider process. Providers always should inform recipients of their HIPAA processes and should obtain releases. |
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| 11. There are no other long term services that provide one-on-one contact for adult mentally ill persons. | 11. See response to number 1 above. |
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| 12. Some providers have committed fraud and abuse in providing this service to their clients. They have bribed clients to change companies. They have entertained clients in private homes and taken them to entertain-ment activities. Providers will adjust and simply give widespread diagnoses of Major Depressive Disorder or Bipolar I in order to fulfill the Axis I requirement. This will result in care that is not client-centered and treatment designed and administered around false diagnoses. The answer to such fraud lies in increased oversight of service provision, fair auditing practices, and enforcement of existing regulations. | 12. Virginia regulation 12VAC30-130-2000 pertaining to marketing requirements and restrictions prohibit companies from offering incentives for individuals to receive services from them.<br><br>Licensed Mental Health Professionals are the only individuals that may provide a mental health diagnosis. Each state licensing board has regulations governing its licensed professionals. LMHPs would be at risk of Department of Health Profession investigations into licensing violations should it be suspected that they are misdiagnosing individuals in order for individuals to meet eligibility criteria for a service.<br><br>See response to number 7 above for further information regarding auditing and enforcement of regulations. |
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| 13. Physician assistants should be added to the definition of Licensed Mental Health Professional in 12 VAC 30-50-226. | 13. Licensed Mental Health Professionals (LMHP) for the purpose of community mental health rehabilitative services are determined by the Department of Behavioral Health and Developmental Services (DBHDS) in 12VAC35-105-20. All provider qualifications for services licensed by DBHDS must follow DBHDS regulations. DMAS will consider this recommendation in conjunction with DBHDS and DHP. |
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| 14. The regulations should include an exception mechanism with ample evidence of serious mental illness and functional deficits. | 14. Emergency regulations 12VAC30-50-226 allows for "any other Axis I mental health disorder that a physician has documented specific to the individual within the past year and that includes all of the following: (i) is a serious mental illness,…(iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record." With this in mind, DMAS believes that the regulations are drafted broadly enough to not require an additional exception mechanism. |
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| 15. Access to services should rely on expert opinion in an independent evaluation (much like the VICAP process used for children). | 15. The VICAP process requires that the individual meet the eligibility criteria of the service being recommended. Requiring a VICAP would not change the outcome of the regulations. However the proposed regulations are being clarified to reflect that the provider must conduct a provider service specific intake that will include specific elements to help the provider ensure and document that the individual meets each of the required eligibility criteria. |
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| 16. Savings from this DMAS service reduction should be returned to the mental health system to assist with building a more robust mental health services system. Additional funding for crisis intervention, crisis stabilization, crisis call centers, peer support and integrated primary and behavioral health care should be considered. | 16. Any cost savings are required by law to be returned to the Virginia General Fund. The General Assembly will determine how that money is appropriated with the recommendation of the Governor and the administration. |
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| 17. Proposed changes require individuals to fail in the community and use more costly and restrictive services before accessing community based services contrary to the current practice of caring for individuals in the least restrictive environment possible. Proposed changes to units and rates will negatively impact rural areas where day-to-day operating costs exceed proposed hourly rates. | 17. See response to numbers 1 and 3 above for further information. |
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| 18. Persons getting mental health support services, lacking a history of hospitalization, will be denied services which will affect their families, many with underage children. | 18. Other community resources are available to assist families with children, including the Department of Social Services. See number 1 above for further information. |
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| 19. Young people should not be required to | 19. Regulations require that individuals under the age of |

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| move out of their parents' homes in order to receive this service.<br>(12 VAC 30-50-226(B)(6)(c)(1)) | 21 be preparing to transition into an independent living situation within 6 months of initiation of services. Individuals may be residing with their parents during that time period. |
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| 20. The regulations require an 'Axis-1 diagnosis'. The current version of the DSM, published in May 2013, abolished the Axis system. This requirement should be removed from the regulations. | 20. DMAS is accepting Axis 1 diagnoses per DSM-IV-TR in order to allow providers to update electronic and operating systems and train staff on the changes per the DSM V. |
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| 21. These regulations establish a more limited definition of what constitutes mental illness and could lead professionals to over-diagnose by assigning a more restrictive label than is clinically justified. | 21. The regulations do not define mental illness. The regulations identify the specific diagnoses that may be considered when determining eligibility for this service.<br><br>Licensed Mental Health Professionals are the only individuals that may provide a mental health diagnosis. Each state licensing board has regulations governing its licensed professionals. LMHPs would be at risk of Department of Health Profession investigations into violations should it be suspected that they are misdiagnosing individuals in order for them to meet eligibility criteria for a service. |
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| 22. Virginia uses a broad definition of mental illness to keep people within state hospitals and commit them to state hospitals, yet proposes a very limited definition to receive community services. These regulations contribute to the bias toward institutional care. | 22. The Code of Virginia §37.2-817 defines what is necessary for institutionalization. The MHSS regulations are not as stringent as the legal requirements for state hospitals. |
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| 23. It is unreasonable to expect a young person who has mental illness to remain in a dysfunctional family system. It is unreasonable to expect such individuals to acquire healthy or adaptive lessons for living independently in home situations that can exacerbate their mental illnesses. | 23. MHSS is designed to assist individuals to learn skills that will allow them to move to an independent living setting. As with any young person moving to a more independent living setting, more than activities of daily living would be required. For individuals with mental illness, as the regulations require coordination with other health professionals, the individual can seek additional assistance like therapy, medication and case management. |
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| 24. The Mental Health Support Services was instituted several years ago to reduce the incidence of repeated psychiatric hospitalizations, incarcerations, interventions by agencies such as Child Protective Services and inappropriate interpersonal relationships with others in the community and within families that increase the threat to others or harm to self. | 24. This comment implies that MHSS services were intended by DMAS to be preventive in nature. Such is not the case. From its onset, this service has always been meant to be rehabilitative in nature. |
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| 25. These changes remove least-restrictive community-based service options for the | 25. Other community based service options are still available. See number 1 above for further information. |

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| most vulnerable mentally ill population. | |
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| 26. Persons with mental illness frequently cannot accurately report treatment histories. They don't always have access to medications and sometimes their illness makes them suspicious of taking drugs. | 26. See number 6 above for further information.<br><br>Regulations do not require individuals to take medication only that they have a prescription within the 12 months prior to initiation of services. |
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| 27. New regulations will not control unethical or dishonest providers but serve only to prevent services being provided to people who need the services. | 27. See number 7 and number 12 above. |
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| 28. DMAS and DBHDS have the ability to fine, demand corrective action or close programs under the current regulations. A failure to regulate the growth [referenced in the agency's statement document], using tools already available should not result in the loss of services for seriously mentally ill individuals. | 28. See number 7 and number 12 above. |
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| 29. The emphasis, in the emergency regulations, on documentation for both psychiatric treatment and psychotropic medications creates a bureaucracy with the sole purpose of stopping access to services. | 29. Emphasis on documentation of psychiatric treatment and psychotropic medication is to ensure proper care coordination of treatment between providers in order to maximize the rehabilitative nature of the service. MHSS is not a substitute for outpatient therapy, medication management or case management. |
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| 30. Concern was expressed about restrictions to obtaining access to housing or GED-related goals. Concern was expressed over requiring clients to be receiving specific medication treatments. Concern was expressed over the new restrictions about qualifiable diagnoses. A client could be at a sub-clinical level of a serious mental illness diagnosis and would be denied the services due to the new criteria. The client could actually develop a clinical diagnosis as a result of being denied the service. | 30. The Department of Medical Assistance Services (DMAS) is charged with assisting Medicaid eligible individuals with accessing medical treatment to include mental health treatment under the authority of Title XIX of the *Social Security Act* (the *Act*). Other state agencies, including but not limited to, Virginia Housing Development Authority, The Department of Aging and Rehabilitative Services, and Department of Education are responsible for overseeing housing, vocation, and GED-related goals. Title XIX of the *Act* does not provide for accessing housing or GED-related goals. It is fraudulent to use XIX funds for these purposes.<br><br>Individuals receiving MHSS are not required to take specific medications, only to have seen a physician related to psychiatric medication within the 12 months prior to admission.<br><br>See number 14 above for further information related to restrictions regarding qualifying diagnosis. |
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| 31. It is contradictory for DMAS to report that individuals with the most severe mental illness will be allowed to receive MHSS but providers will not be allowed to work therapeutically with these individuals and | 31. MHSS allows for training in functional skills such as daily living skills, coping skills, anger management, and social skills to assist individuals in increasing access to community supports and maintaining health and safety. It is not intended as an all-encompassing stand-alone |

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| must limit their interventions to basic skills training. Pigeonholing providers into just doing surface skills training will not allow for stabilization of clients in the community. | service and the use of outpatient therapy, medication management, and other community resources are to be used in assisting with the stabilization of individuals in the community. |
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| 32. The emergency regulations were not submitted properly and timely and should be withdrawn. | 32. Due to the delay in the executive review of this action, DMAS' authority carried over to the *2013 Acts of the Assembly*, Chapter 806, Item 307 LL. |
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| 33. A physician cannot accurately and fully determine a patient's functional limitations when they do not have access to the patient's home and are completely dependent upon patient report. | 33. Individuals appropriate to receive MHSS with an Axis I disorder other than Major Depressive Disorder, a psychotic disorder, or Bipolar Disorder, would be actively seeking services or would be referred by another mental health provider. Such individuals therefore would either be forthcoming with enough information to assist the physician in determining that there are significant functional limitations or the physician would have additional information from the referring provider or family member. |
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| 34. Those with a history of homelessness, cognitive restrictions, or involvement with the criminal justice system that contribute to their mental or emotional wellbeing are no longer eligible for services. | 34. There is no limitation of the service for those with a history of homelessness or involvement with the criminal justice system. Individuals with a history of homelessness or criminal justice system, whose history is due to their mental illness, will most likely, continue to meet criteria for services due to psychiatric symptoms/diagnoses that caused the homelessness/criminal history. Individuals with cognitive restrictions may receive the service so long as a physician documents the medical necessity for this service as required in the regulations. |
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| 35. The need for documentation of prior mental health history and psychiatric medication will result in a delay in obtaining services. | 35. Regulations only require a telephone contact to be made with the previous health care provider or pharmacy to confirm what the individual has reported. It is customary standard medical practice that a service intake includes determining previous treatments and providers. The regulations specify only certain elements to be documented, not every treatment or every provider ever involved with the individual. This should be a routine activity for intake process. |
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| 36. Requiring individuals under age 21 to be in an independent living situation but those over 21 not to be is age discrimination. Rather than require an MD to say medications are contraindicated, require that individuals be "under a physician's active care and review." Service plans with specific frequencies do not allow for crisis situations and changes to the individuals life. | 36. Individuals under the active care and review of a physician would either have a prescription for medication or the clinical notes of the physician would indicate that medication is contraindicated. No age restrictions will apply.<br><br>Individual Service Plans may be updated as needed to adjust for changes in life circumstances and crisis situations. Providers should bear in mind that crisis intervention is not and has not been a component of this service.<br><br>The currently effective emergency regulations assume that an individual older than 21 years of age are already |

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| | living independently in the community. |
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| 37. Ample time was not given to providers to prepare before the changes went into effect. | 37. DMAS began publically discussing upcoming changes to MHSS in November 2012. In March 2013 information and frequently asked questions regarding proposed changes were posted to the DMAS website. Providers were given 30 days notice prior to the regulations being implemented with a rolling implementation to allow more time for individuals with already approved service authorizations to remain in services under the old regulations. |
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| 38. Individuals are at the mercy of community entities to submit the needed materials which could potentially take months to obtain. This process will be a deterrent to services. | 38. See number 34 above. |
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| 39. No amount of intensive training over six months or one year will render most individuals able to "graduate" and function independently with no support. | 39. MHSS services are intended to provide training in functional skills. Other community mental health services are available for support during and after discharge from MHSS. See number 1 above for further information. Like other MH services, the provider is responsible for continuously assessing the individual's needs and progress or lack of progress toward the goals and objectives in the ISP. The ISP is to be updated/revised as progress or lack of progress is being made. The regulations do not limit the service to a single year, however re-authorization is dependent on the individual demonstrating his improving condition from the service. If there is no progress, then another level of service may be needed or the individual's ability or willingness to actively participate in the service needs to be explored and confirmed. |
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| 40. There is no therapeutic benefit of service hours being done only within a certain amount of allotted days. | 40. There are no restrictions on the number of days per week that services may be offered. Providers may not exceed the number of days per week in the ISP however they do not need to use all of them. Requirements for documentation of the number of hours and days per week that services are necessary is intended to encourage providers to routinely review the ISP and adjust goals/frequencies to match the needs of the individual. |
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| 41. Therapeutic foster care workers are not required to provide independent living skills training and therefore individuals in TFC should be able to receive the service. | 41. Virginia regulations pertaining to foster care require that if independent living is a goal of foster care for a child that the Department of Social Services shall provide services related to that goal. DMAS regulations 12VAC30-130-900 note that services are to be provided primarily by the treatment foster care family who are trained, supervised and supported by DSS staff. Allowing MHSS for youth in TFC would be a duplication of services. |
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| 42. Individuals with onset of mental illness may not have a prior mental health history | 42. Prior psychiatric hospitalization is just one element of one component of the eligibility criteria. See number 1 |

| of hospitalization | above for more information. |
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## Family impact

*Please assess the 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;. The changes should encourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself as they focus on assisting individuals to become more independent, increase community integration and lessen reliance on caretakers. It does not strengthen or erode the marital commitment.

To the extent that family members who have mental illness regress into harmful behaviors, the effect of these regulations on some families could be severe. However, the regulations do require care coordination with other mental health providers who can assist in determining decompensation symptoms prior to a crisis.

## Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action.*

*If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all differences between the **pre**-emergency regulation and this proposed regulation, and (2) only changes made since the publication of the emergency regulation.*

| Current section number | Proposed new section number, if applicable | Current requirement | Proposed change, intent, and likely impact of proposed requirements |
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| 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 |

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| | | | 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. |

Stakeholders:

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| 1. | Mary Ann Bergeron | VA Assn of CSBs |
| 2. | Mike O'Connor | Henrico CSB |
| 3. | Molly Cheek | Dominion Youth Services |
| 4. | Anne Henley | Family Solutions |
| 5. | Betty Etzler | Family Preservation Services |
| 6. | Jennifer Fidura | Va Network of Private Providers |
| 7. | Nancy Toscano | United Methodist Family Svcs |
| 8. | Cindy Faison | St. Joseph's Villa |
| 9. | Henry Koch | Virginia Support Services |
| 10. | Pat Harris | Family Focus |
| 11. | Tenesha Henderson | NDUTime |
| 12. | Terri Tuck | Healthcare Administrative Services |
| 13. | Bridget Hundley | Mountain River Counseling |
| 14. | Deborah Sikes | National Counseling Group |
| 15. | Rick Provenzano | Children's Services of Virginia |
| 16. | Dean East | East Mental Health |
| 17. | Les Saltzberg | Department of Behavioral Health |
| 18. | John Pezzoli | Department of Behavioral Health |
| 19. | Heidi Lawyer | VA Board for People with Disabilities |
| 20. | Margaret Nimmo Crowe | Voices for VA's Children |
| 21. | Mira Signer | NAMI Virginia |
| 22. | Bonnie Neighbor | VOCAL |
| 23. | Stephen Jurentkuff | VCOPPA |
| 24. | Donnie Pennington | KePro |
| 25. | Christie Watson | HMS |