**Virginia Regulatory Town Hall**

# Final Regulation
# Agency Background Document

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| **Agency Name:** | 12 VAC 30 |
| **VAC Chapter Number:** | Chapter 50 |
| **Regulation Title:** | Amount, Duration, and Scope of Services: EPSDT Services |
| **Action Title:** | EPSDT Residential Psychiatric Treatment for Children |
| **Date:** | 11/1/2000 |

Please refer to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99) , and the *Virginia Register Form,Style and Procedure Manual* for more information and other materials required to be submitted in the final regulatory action package.

## Summary

*Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment; instead give a summary of the regulatory action. If applicable, generally describe the existing regulation. Do not restate the regulation or the purpose and intent of the regulation in the summary. Rather, alert the reader to all substantive matters or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. Please briefly and generally summarize any substantive changes made since the proposed action was published.*

This final adopted regulation establishes the coverage of residential psychiatric services for children and adolescents under the authority of the Early and Periodic Screening, Diagnosis, and Treatment program.

## Changes Made Since the Proposed Stage

*Please detail any changes, other than strictly editorial changes, made to the text of the proposed regulation since its publication. Please provide citations of the sections of the proposed regulation that have been altered since the proposed stage and a statement of the purpose of each change.*

| VAC Citation | Substance of the Suggested Change |
|---|---|
| 12VAC30-50-130 | Addition of accrediting organization for participating facility providers. |

## Statement of Final Agency Action

*Please provide a statement of the final action taken by the agency: including the date the action was taken, the name of the agency taking the action, and the title of the regulation.*

The Director of the Department of Medical Assistance Services adopted these final regulations on November 1, 2000, in lieu of the Board of Medical Assistance Services.

## Basis

*Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority, shall be provided. If the final text differs from that of the proposed, please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.*

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, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Director approved, on April 13, 2000, the initiation of a public comment period for the proposed regulations. The Code, in § 9-6.14:7.1 et seq., requires agencies to adopt and amend regulations subject to public notice and comment when the action being taken does not meet one of the statutory exemptions.

Subsequent to an emergency adoption action, the agency initiated the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on January 1, 2000. The Code, at §9-6.14:4.1(C) requires the agency to file the Notice

of Intended Regulatory Action within 60 days of the effective date of the emergency regulation if it intends to promulgate a permanent replacement regulation. The Notice of Intended Regulatory Action for this regulation was filed with the Virginia Register on January 6, 2000.

Chapter 464 of the 1998 Acts of Assembly, Item 335.X.2 mandated that the Department promulgate regulations to amend the State Plan for Medical Assistance to expand coverage of inpatient psychiatric services under the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) to include services in residential treatment facilities. The Act mandated that such regulations be in effect on January 1, 2000, and address coverage limitations and utilization review. Such services, defined at 42 CFR § 440.160, are nevertheless being covered herein under the authority of 42 CFR § 440.40.

## Purpose

*Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the final regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.*

The purpose of this rule is to provide Medicaid reimbursement for a new service: residential psychiatric services for children and adolescents under the Early and Periodic Screening, Diagnosis and Treatment service. Since this will be a newly covered service, the health of Medicaid children who need this service will be benefited.

## Substance

*Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement of the regulatory action's detail.*

The sections of the State Plan affected by this action are the Amount, Duration, and Scope of Services Early and Periodic Screening, Diagnosis and Treatment service (12 VAC 30-10-150, 50-30, 50-130, 50-250, 80-21). The regulations affected by this regulatory action are Amount, Duration, and Scope of Services Early and Periodic Screening, Diagnosis and Treatment Residential Psychiatric Treatment for Children and Adolescents (12 VAC 30-130-850 et. seq).

The Comprehensive Services Act for At-Risk Youth and Families (CSA) (§§ 2.1-745 through 2.1-759.1 of the Code of Virginia) is a Virginia law designed to help troubled youths and their families. State and local agencies, parents, and private service providers work together to plan and provide services. In each community, local teams decide how to do this. The community policy and management team (CPMT) coordinates agency efforts, manages the available funds, and sees that eligible youths and their families get help. The family assessment and planning

team (FAPT) looks at the strengths and needs of individual youths and families, decides what services to provide, and prepares a service plan for each family. Both teams include parents, staff from community service boards, court service units, the Departments of Health and Social Services, the schools, and private providers.

In 1997, the Joint Legislative Audit and Review Commission (JLARC) published its "Review of the Comprehensive Services Act." This report made a number of recommendations for improvement of the Comprehensive Services Act. One recommendation urged the use of Medicaid funding to serve children whose placements were in facilities and programs for which Medicaid payment could be made. In this way, federal matching funds could be obtained for services currently funded from State and local funds. As a result of the JLARC report, the 1998 Appropriations Act directed the Department of Medical Assistance Services to add coverage of residential treatment for children and adolescents to the coverage of inpatient psychiatric treatment under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Medicaid coverage of this new residential treatment became effective on January 1, 2000.

Before the emergency rule became effective, Medicaid covered inpatient psychiatric treatment for individuals under age 21 only in psychiatric units of acute care general hospitals or in freestanding psychiatric hospitals. This regulation will provide a lower, less intensive, level of inpatient services for children and adolescents who do not require the intensity of services offered by a hospital setting.

Prior to the current emergency regulations, residential psychiatric services were purchased by the Comprehensive Services Act for children and adolescents who could not be treated on an outpatient basis and who did not need hospital care. These placements were funded from state and local funds. Since Medicaid now covers the service, federal matching funds are available and reduce the amount of state and local funds needed to purchase residential services for these vulnerable children.

The regulations include the definition of the service, coverage limitations, provider qualifications, utilization review, and reimbursement methodology.

The provision of these services through Medicaid will make it possible for children and adolescents who need this service to access it quicker (spending less time on waiting lists) and from a larger number of enrolled providers. This should facilitate service provision, enabling children and adolescents to get better faster and return to their regular life routine.

The only difference between these final adopted regulations and the previously proposed regulations is the addition of The Council on Quality and Leadership as another acceptable accrediting organization for enrolled providers.

## Issues

*Please provide a statement identifying the issues associated with the final regulatory action. The term "issues" means: 1) the advantages and disadvantages to the public of implementing the new provisions;*

*2) the 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 there are no disadvantages to the public or the Commonwealth, please include a sentence to that effect.*

The primary advantage of this action is the addition of a Medicaid reimbursable service to replace a service currently paid from only State and local funds. By making federal funding available, savings can be achieved in state General Funds and in expenditures of local governments for children and adolescents served through the Comprehensive Services Act.

The primary disadvantage of this regulation action arises from the federal mandated requirements for Medicaid reimbursement. The federal regulations are prescriptive of provider requirements and utilization management requirements. Because of the prescriptive provider requirements, only a few of the residential care facilities licensed in the Commonwealth can participate in Medicaid payments. These regulations reflect the current federal regulations.

Providers of residential treatment may resist the additional cost of complying with Medicaid's federal regulations. In addition, they may resist Medicaid reimbursement methodologies. Prior to the emergency rule, each facility negotiated a unique rate of reimbursement with each local Community Policy and Management Team. The fact that Medicaid will be paying for this service will force the standardization of payment rates. Local governments will have to consider Medicaid reimbursement policies when referring Medicaid eligible children to a Medicaid enrolled residential treatment provider.

## Public Comment

*Please summarize all public comment received during the public comment period and provide the agency response. If no public comment was received, please include a statement indicating that fact.*

SUMMARY OF PUBLIC COMMENTS AND AGENCY RESPONSES

EPSDT RESIDENTIAL PSYCHIATRIC SERVICES FOR CHILDREN AND ADOLESCENTS

12 VAC 30-10-150; 50-30, 70, 130, 250; 80-21; 130-850

DMAS' proposed regulations were published in the July 31, 2000, Virginia Register for their public comment period from July 31 through September 29, 2000. In addition to the Register publication, DMAS forwarded these proposed regulations to the Barry Robinson Center, Lutheran Family Services, People Places, Highlands Community Services Board, Hampton-Newport News Community Services Board, Phillips Programs, and CARPE DIEM of Virginia. Comments were received from Fairfax County Human Services Community Policy and Management Team and Grafton. A summary of the comments received and the agency's response follow.

Grafton Comments:

Grafton indicated that it is a provider of services to many Virginia children who qualify for these services, including those with both psychiatric and mental retardation diagnoses. Grafton stated that it had just recently been accredited by The Council on Quality and Leadership with which it had been working closely for years. Grafton stated that The Council is known to have proven standards of quality for providers of treatment services. Grafton requested that DMAS include, in its permanent final regulations, The Council as an acceptable accrediting organization for enrolled providers of Residential Psychiatric Treatment Services for children and adolescents under Medicaid.

Response:

DMAS concurs with adding The Council on Quality and Leadership as another accrediting organization for enrolled providers of residential psychiatric treatment services for children and adolescents. This change has been added to the final, adopted regulations.

Fairfax-Falls Church Community Policy and Management Team (Fairfax County Human Services) Comments:

The first comment took issue with several points contained in the Department of Planning and Budget's Economic Impact Analysis (EIA). This EIA referenced the Joint Legislative Audit and Review Commission's (JLARC) report entitled "Review of the Comprehensive Services Act". "JLARC estimated the total FY 1997 CSA population which could potentially have treatment funded by Medicaid. FY2001 Medicaid targeted expenditures for Fairfax-Falls Church are approximately $15.9 million. After a local review of the number of CSA funded youth who are Medicaid eligible, the number of locally contracted providers who are Medicaid enrolled, and the number of youth who meet the medical necessity criteria, our estimates suggest the Medicaid expenditure target to likely be only $4.1 million".

The commenter further stated that only "a portion of the total daily costs of the therapeutic foster care and residential treatment services are covered by Medicaid, and fewer residential treatment providers currently meet the enrollment criteria than estimated". The commenter also stated that, as of September 8, 2000, although this Community Planning and Management Team had local contracts with 54 residential providers, only 9 were enrolled with Medicaid for residential services. This CPMT expressed serious concerns regarding the state's estimated cost savings under Medicaid.

Another issue in the EIA about Medicaid decreasing the average length of stay for some recipients through active monitoring of cases drew this comment. "It has been our experience that the medical necessity criteria under Medicaid cover fewer days than the length of time required to meet a child's treatment/service goals as determined by FAPTs. CSA funds will, therefore be needed to purchase the additional days required to meet goals and will ultimately not result in significant fiscal savings".

This commenter noted that the proposed regulations appeared to be the same as the currently effective emergency regulations. This locality has developed procedures and internal processes to comply with these regulations.

This commenter expressed further concern about the inconsistencies in the interpretation of DMAS policy by the West Virginia Medical Institute (WVMI) and cited to specific inconsistencies with regard to interpretation of Independent Team Certification.

"The Independent Certifying Team is defined in 12 VAC 30-130-860 …. as "includes a licensed physician, has competence in diagnosis & treatment of pediatric mental illness, has knowledge of the recipients mental health history and current situation". The commenter stated that the FAPTS (Family Assessment and Planning Team) in Fairfax-Falls Church do not have a physician member. The commenter further indicated the FAPT level of care approval process, facility selection, obtaining the certificate of need from the CSB licensed physician are handled by the social worker prior to placing the child. DMAS requires that the CON (Certificate of Need) be signed by the FAPT as well as the CSB psychiatrist, requiring the FAPT to re-convene. The issue was that the "increased workload for teams and the cost of staff time to reconvene is significant".

The commenter indicated that although WVMI had previously approved several youth for whom the provider submitted a CON with accompanying Individual Family service Plan signed by the FAPT, recently, pre-authorization has been denied and DMAS has informed the county that the FAPT must sign the CON. The inconsistent application of the regulations and redundancy of requirements for FAPT signatures on both forms is both costly and cumbersome.

This commenter stated that the proposed regulations (at 12 VAC 30-90-890) refer to the use of the 'Child and Adolescent Functional Assessment Scale (CAFAS®)/Preschool and Early Childhood Functional Assessment Scale (PECFAS®) and that DMAS requires the use of this form for youth under the age of four years. This agency consulted with the form's author and has determined that this form has not been validated for children of this age. "Fairfax-Falls Church is not going to request our professionally trained staff to rate an instrument that does not have validity for this population, and we therefore recommend that the PECAFAS® not be required for youth under four years".

This commenter further detailed the difficulties it encounters with CAFAS submissions with documentation for continued stay reviews and its schedule of FAPT reviews. Further reference is given to the State Executive Council's Virginia Utilization Review Procedures for CSA (dated August 28, 1998) as requiring the CAFAS rating to be completed every three months for children on levels two-six" such as residential psychiatric services. "It is not always possible to meet the DMAS timeline based on the existing 90-day cycle" forcing providers "to delay their continued stay review until an updated CAFAS® is completed. Such situations "will result in denial due to a "late" CAFAS®.

The commenter believed that this same situation also applied to Treatment Foster Care (other proposed regulations), as published on page 2871 of the Virginia Register (Volume 16, issue 23, published July 31, 2000).

The commenter summed up as follows:

? "DMAS and WVMI processes for submission and approval are extremely cumbersome and time consuming and much costlier than anticipated for providers and local staff.

? "WVMI is inconsistent with its deadlines for providers with regard to response time to questions about case submissions, the time can range from four days to two weeks.

? "DMAS resources dedicated to processing case submissions appear to be limited and insufficient, i.e., providers have advised our locality that only one facsimile machine number is available statewide for both receiving and sending information, apparently resulting in significant delays in payment to providers".

? The Fairfax-Falls Church CPMT recommended that with the adoption of the permanent proposed regulations for Residential and [sic] Psychiatric Treatment for Children and Adolescents, DMAS and WVMI should clarify policy and procedures for their implementation in writing and share them with localities, thereby ensuring consistency. It is further recommended that DMAS enhance effectiveness and efficiency by instituting an automated system for submission, approvals and appeals".

Response: The DMAS response follows the same sequence as the comments above.

The Department of Planning and Budget's Economic Impact Analysis (EIA) was based on a study previously conducted by the Joint Legislative Audit and Review Commission (JLARC) of the Comprehensive Services Act (CSA). DPB's use of this previous study was appropriate, at the time of the development of the EIA, because it was the only available study of the CSA. The statute requiring DPB's preparation of an EIA only permits 45 days for this activity's completion thereby not permitting time for DPB to prepare and conduct a study of its own.

If there were design flaws in the JLARC study, it was beyond the purview of DPB, in the Article 2 rule making process, to either modify the study or the results. In fact, the JLARC study formed the basis of the General Assembly's decision to restructure the CSA program. DMAS, therefore, recommends that this commenter take up these issues with JLARC and the General Assembly as the issues are beyond the purview of this agency's rule making process to address.

From the outset of discussions with stakeholders regarding Medicaid coverage of residential psychiatric treatment services, it has been clear that not all "residential" facilities would meet the requirements to qualify for Medicaid reimbursement. In fact, some local agencies consider 'group homes' to be residential treatment facilities. In the absence of medical treatment, DMAS is federally prohibited from reimbursing for individuals in such facilities. Local agencies have no such federal prohibition on their payments to 'group homes'.

It is the responsibility of the FAPT and the CPMT to accurately describe a child's condition and need for services in the child's Plan of Care. If there are issues with Medicaid not covering a long enough length of stay for a child, then perhaps the problem is not the adequacy of the

medical necessity criteria but the adequacy of the documentation and explanation of the child's medical needs. Medicaid is always interested in paying only for care that is medically necessary.

To date, WVMI has not denied a single stay of a child in a residential treatment facility due to not meeting medical necessity.

The proposed regulations are indeed very similar to the currently operating emergency regulations. Therefore, DMAS is perplexed, since this commenter stated that this locality had formulated procedures and internal policies to comply with the emergency regulations, why this locality should be having such difficulties complying with the regulations.

The requirement for CON or independent evaluation prior to admission to an inpatient psychiatric facility for individuals younger than age 21 has been in place since 1993. The Code of Virginia also requires certain minors to be evaluated by an independent evaluator to certify the need for admission for a psychiatric stay.

DMAS does not require a specific form for the CON. DMAS has indicated in training that the three statements may be incorporated into the FAPT assessment and the physician can sign the CON after the FAPT members have signed. DMAS has clearly stated that the physician should have available to him all information on which the decision was made to place the child in a residential facility. The regulations and the manual clearly state that a team including a physician must complete the CON. Nowhere do DMAS' regulations state that the FAPT must re-convene in order for the physician member to sign the CON. If the written documentation provides a clear, complete, thorough explanation of the child's status and need for residential treatment, then re-convening of the FAPT should not be necessary in order to secure the physician's signature. The signing physician should not be relying on verbal information conveyed in meetings to issue his approval signature for the admission of a child.

DMAS acknowledges that, at one time, it permitted its pre-authorization contractor West Virginia Medical Institute (WVMI) to authorize residential treatment services when the proper documentation was not submitted. This was done in an effort to accommodate localities during a period of transition, while localities modified internal procedures and policies, to Medicaid's administration of this service. However, after a transition period, DMAS instructed WVMI to adhere to program requirements. It is unfortunate that this commenter chose to look at the pre-authorization denials as a roadblock to what it desired rather than an opportunity to tweak its internal procedures to more effectively and efficiently attain the necessary requirements toward the ultimate of goal of providing residential treatment care for a child.

With regard to the "inconsistent" deadlines for responding to questions on case submission, DMAS provides this response. If the information submitted by a provider is complete but WVMI needs clarification in order to process the review, the case is held in suspension for 10 days. WVMI sends a request to the provider for additional information. If the provider's information as submitted is still not what is needed to complete the review process, another request is sent to the provider within the original ten days. All suspended case reviews are either approved or denied within the original ten days so there is no inconsistency.

WVMI has a number of fax machines. If the machines dedicated to Residential and Treatment Foster Care are busy, incoming calls roll to the next available machine. If at anytime a provider gets a continual busy signal, the provider should call WVMI. WVMI is committed to assuring an efficient process and will increase equipment as the volume indicates.

The regulations do not make any reference at all to the CAFAS/PECFAS® but instead reference a state designated uniform assessment instrument. The DMAS Psychiatric Services manual states that the CAFAS® is required. If there is no CAFAS® or PECFAS® instrument submitted at all, the stay will be denied. DMAS and the Office of Comprehensive Services agree that these CAFAS® or PECFAS® instruments should be completed, where applicable, with a note that the evaluated child is either below or above the recommended age for the instrument. WVMI accepts the CAFAS/PECFAS® forms that are partially completed for children who are ages younger than four and older than 17 years old.

Medicaid covered Residential Treatment is not included in the CSA State Executive Council's utilization review procedures and, therefore, cannot be compared to that process. DMAS' requires the CAFAS® to have been completed no more than 90 days prior to the request for review. If a request for review were submitted on 9/1/00, the completion of the CAFAS/PECFAS® could not precede 6/1/00 in order to be acceptable documentation for service approval. By the next review for that individual, the CAFAS® would need to be updated.

And finally, DMAS' policies and procedures are already in writing. Providers and localities should consult the Psychiatric Services Provider Manual on the DMAS website www.cns.state.va.us/dmas. This manual has also been mailed to enrolled providers.

## Detail of Changes

*Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or crosswalk - of changes implemented by the proposed regulatory action. Include citations to the specific sections of an existing regulation being amended and explain the consequences of the changes.*

| VAC Citation | Substance of the Suggested Change |
|---|---|
| 12VAC30-50-130 | Addition of accrediting organization for participating facility providers. |

## Family Impact Statement

*Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which 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.*

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This regulatory action will have positive affects on the institution of the family and family stability by providing previously unavailable Medicaid coverage for this residential psychiatric treatment service. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.