Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-50-130; 12VAC 30-50-226; 12VAC 30-60-61; 12 VAC 30-60-143; and 12VAC 30-130-2000
Regulation title	Amount, Duration and Scope of Medical and Remedial Services; and Standards Established and Methods Used to Assure High Quality of Care; Marketing Requirements and Restrictions (new)
Action title	2011 Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications
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.

The agency is proposing this regulatory action to comply with Chapter 890, Item 297 YY, of the 2011 *Acts of Assembly* that gives DMAS authority to make programmatic changes in the provision of Community Mental Health Rehabilitative Services (specifically Intensive In-Home services and Community Mental Health Support services) in order to ensure appropriate utilization, cost efficiency and provider qualifications appropriate to render these Medicaid covered services. This action includes: (i) changes to provider qualifications including meeting licensing standards; (ii) marketing requirements/restrictions; (iii) new assessment requirements, and; (iv) language enhancements for utilization review requirements to help providers avoid payment retractions. These changes are part of a review of the services to ensure that they are appropriately utilized for individuals who meet the medical necessity criteria. New Independent Clinical Assessments, conducted by local community services boards or behavioral health authorities (CSBs/BHAs), are being required prior to the onset of specified services until DMAS' Behavioral Health Services Administrator contractor can assume this responsibility. Providers that are permitted to claim Medicaid reimbursement for specific services are specified by license type.

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.

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 agency is proposing this regulatory action to comply with Chapter 890, Item 297 YY, of the 2011 *Acts of Assembly* that gives DMAS authority to make programmatic changes in the provision of Intensive In-Home (IIH) services and Community Mental Health services (CMHS) in order to ensure appropriate utilization, cost efficiency, and improved provider qualifications. In recent years, the utilization of certain community-based mental health services has substantially increased. These changes are part of an agency review of the services being rendered and reimbursed to ensure that they are appropriately utilized and medically necessary. Specifically, the referenced section of the 2011 *Acts of Assembly* states:

"YY. The Department of Medical Assistance Services shall make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriation utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The Department of Medical Assistance Services shall promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."

These enclosed proposed utilization control requirements are recommended consistent with the federal requirements at 42 CFR Part 456 Utilization Control. Specifically, 42 CFR § 456.3 **Statewide surveillance and utilization control program** provides: "The Medicaid agency must implement a statewide surveillance and utilization control program that—

"(a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;

"(b) Assesses the quality of those services;

"(c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part, and

"(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part."

The 2011 *Acts of Assembly* also authorized the Department of Medical Assistance Services (DMAS) to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization (Item 297, MMMM). The overall goals of this care coordination model are twofold: 1) improve the coordination of care for individuals, who are receiving behavioral health services, with acute and primary services; and 2) improve the value of behavioral health services purchased by the Commonwealth without compromising access to these services for vulnerable populations. Pursuant to this directive, DMAS is soliciting a proposal for a Behavioral Health Services Administrator (BHSA) for members enrolled in Virginia's Medicaid/FAMIS Plus/FAMIS programs who are receiving behavioral health services not currently provided through a managed care organization but through the fee for service system. The selected BHSA will only provide administrative services including, but not limited to, care coordination activities, authorizing, monitoring, and encouraging appropriate behavioral health service utilization. The implementation of the new care coordination model will occur approximately six months after the BHSA contract is awarded.

The *Code of Federal Regulations* also provides, at 42 CFR 430.10, "……The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program." FFP is the federal matching funds that DMAS receives from the Centers for Medicare and Medicaid Services. Not performing utilization control of the services affected by these proposed regulations, as well as all Medicaid covered services, could subject DMAS' federal matching funds to a CMS recovery action.

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.

This regulatory action is not essential to protect the health, safety, or welfare of all citizens. It is essential to protect the health, safety, and welfare of Medicaid individuals who require behavioral health services. In addition, these proposed changes are intended to promote improved quality of Medicaid-covered behavioral health services provided to individuals.

This regulatory action is also essential, based upon DMAS' anecdotal knowledge, to ensure that Medicaid individuals and their families are well informed about their behavioral health condition and service options prior to receiving these services. This ensures the services are medically necessary for the individual and are rendered by providers who do not engage in questionable patient recruitment and sales tactics.

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.)

The regulations affected by this action are the Amount, Duration and Scope of Services (12 VAC 30-50-130 (skilled nursing facility services, EPSDT, and family planning) and 12 VAC 30-50-226 (community mental health services for children and adults); Standards Established and Methods Used to Assure High Quality of Care (12 VAC 30-60-61 (utilization review of services related to the EPSDT program) and 12 VAC 30-60-143 (community mental health services for children and adults and mental health services utilization)). New regulations entitled Marketing Requirements and Restrictions (12 VAC 30-130-2000) and Behavioral Health Services (12 VAC 30-130-3000 et seq) are being proposed.

DMAS has covered certain residential and community mental health services (including Intensive In-Home services to children and adolescents under age 21, Therapeutic Day Treatment, Level A Community-Based Services for Children and Adolescents under 21, Therapeutic Behavioral Services (Level B), Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, Crisis Intervention, Intensive Community Treatment, Crisis Stabilization, and Mental Health Support Services) for a number of years. These services are non-traditional mental health services and are typically only covered by Medicaid.

Since SFY 2007, the use of these services has grown dramatically with their related expenditures. For example, reimbursements for Intensive In-Home services grew one and a half times to $129,337,031 in SFY 2010. Therapeutic Day Treatment reimbursement increased more than three and one half times to $166,079,326 over the same time. Reimbursement for Mental Health Support Services (12 VAC 30-50-226) grew four and one half times to $138,190,634 over the same time period.

Some of the growth in service usage has been due to more community-based services being provided. The proposed changes included in this package are intended to improve the quality of rendered services, by requiring that providers meet specified licensing and qualification standards in order to be paid by Medicaid.

The proposed changes are also intended to better ensure the appropriate utilization of services by requiring the completion of the new Independent Clinical Assessments (ICA) by the CSBs. DMAS believes that this new ICA step will significantly reduce, if not eliminate, the provision of these community mental health services by providers to individuals whose circumstances do not warrant such serious mental illness diagnoses. Having such serious mental illness diagnoses can negatively affect individuals' future access to educational and employment opportunities. For the application of this new ICA requirement, DMAS is proposing new sections of regulations in Chapter 130 in the 3000 number series.

These affected sections also set forth rules and penalties related to the marketing of Medicaid mental health services. (set out in 12 VAC 30-130-2000 Part VII.)

This action also implements the results of a federal review of residential and community mental health services for children and adults. After reviewing records, the Centers for Medicare and Medicaid Services (CMS) expressed concern about recipients not meeting the established criteria for children's mental health services. This federal review also cited the issue of providers merely copying individuals' progress notes across multiple dates of service and not providing any differentiation across different dates of service. The elements that will be required for service-specific provider assessments are being enumerated so that providers' documentation about individuals' problems and issues adequately supports the providers' reimbursement claims. Provider documentation which does not support reimbursement claims have been subject to payment recoveries.

This action also makes technical corrections such as changing the name of the Department of Mental Health, Mental Retardation, and Substance Abuse Services to the Department of Behavioral Health and Developmental Services (DBHDS).

Section 12 VAC 30-50-130 B contains the Medicaid requirements for the coverage of services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Pursuant to 42 CFR §§ 440.40(b) and 441.50 *et seq*., these controlling federal regulations set out the requirements for this program of well-child preventive health services for Medicaid individuals from birth through the age of 21 years. In 1989, in the context of the federal *Omnibus Budget Reconciliation Act of 1989* (§ 6403), Congress established that Medicaid programs were required to provide all medically necessary services, identified as needed as a result of an EPSDT screening, without regard to whether or not the needed services were otherwise covered under that state's State Plan for Medical Assistance. Services provided under the authority of this regulation can only be covered for children.

The changes proposed for this regulation remove the coverage of a week of Intensive In-Home services without prior authorization and instead require service authorization at the onset of this service. This is intended to eliminate claims processing issues that have delayed payments to providers. Requirements for service-specific provider assessments and Individual Service Plans are also proposed. The categories of licensed professionals who will be reimbursed for these services are specified.

Service (prior) authorization is proposed for Therapeutic Day Treatment for children and adolescents to reflect the current policies.

A new provision is added that services rendered which are based on old (more than a year old) information, missing/incomplete assessments/Individual Service Plans will be denied payments. A new Definition section is proposed. DMAS is incorporating by reference several professional definitions from the Department of Behavioral Health and Developmental Services (DBHDS). Providers which are appropriate to render specific services are listed.

Section 12 VAC 30-50-226 provides for Community Mental Health Services, including day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization, and mental health support services. These services are covered for both children/adolescents and adults. DMAS is specifying, in this proposed action the

types of licensed professionals, consistent with DBHDS' licensing standards, who will be permitted to render these services for purposes of claiming Medicaid reimbursement. The Definition section is expanded to provide for terms used in this section, such as Individual Service Plan and service authorization. This section requires that service-specific provider assessments (as defined in 12 VAC 30-50-130) be prepared to document how the individual to be treated meets the criteria for this service. Absent such documentation, DMAS cannot determine if the rendered services were appropriate for the individual's diagnosed medical needs and therefore retracts payments to providers. References to case management are changed to care coordination, as part of the Intensive Community Treatment package of services, in response to comments from CMS. A few non-substantive, technical edits are proposed for purposes of regulatory parallel construction across subsections.

12 VAC 30-60-5 is newly created to contain several overarching requirements that will be applied to utilization reviews of all Medicaid covered services. This new section specifically reiterates the general applicability of the Chapter 60 utilization review requirements to all Medicaid covered services without regard to whether these requirements are repeated for each specific covered service.

Section 12 VAC 30-60-61 provides the utilization review requirements for EPSDT services (as set out in 12 VAC 30-50-130) which must be met by providers in order to claim reimbursement from Medicaid. These proposed changes require: (i) provider documentation and supervision requirements are enhanced; (ii) completion of an individual service plan within a specified time period; (iii) individual-specific provider progress notes; (iv) provider licensure by DBHDS; (v) provider enrollment with DMAS; (vi) maintaining currency of the individual service plan; (vii) provider compliance with DMAS' marketing requirements, and; (viii) provider collaboration with the individual's primary care provider. A new Definition subsection is created.

This proposed stage also sets out the elements that must be included, for purposes of Medicaid reimbursement, in the service-specific provider assessments in order to justify why and how a Medicaid individual requires these covered mental health services. This proposed stage requires that the initial service-specific provider assessment for Intensive In-Home (IIH) services be conducted in the home and that they be appropriately reviewed and signed and dated. IIH providers must be licensed by DBHDS as well as being enrolled with DMAS. Claims for services based on outdated or incomplete provider assessments will not be paid. If there is a lapse in services for an individual of more than 31 consecutive calendar days, the provider must discharge the individual from his care. If this discharged individual continues to need these services, then the provider must conduct a new assessment for re-admission and must obtain a new service authorization. Providers of IIH will be required to document coordination of services with case management service providers. Providers of IIH will be required to adhere to DMAS marketing requirements and limitations.

Providers of Therapeutic Day Treatment (TDT) services will be required to be licensed by DBHDS as well as being enrolled with DMAS. TDT providers must prepare service-specific provider assessments, before the onset of services, which must also be appropriately reviewed and signed/dated. This proposed stage requires documented coordination with providers of case management services. Providers are required to adhere to DMAS’ marketing requirements set

out in 12 VAC 30-130-2000 for the purpose of receiving Medicaid reimbursement for services rendered. Provision is made for how lapses in services are to be handled.

Providers of Level A residential treatment services, called Community-Based Services for Children and Adolescents, must be licensed by the Department of Social Services or the Department of Juvenile Justice. Service authorization is required for all Level A services before the services will be reimbursed. Service-specific provider assessments and Individual Service Plans must be developed, appropriately reviewed, signed/dated, and must be kept up to date as the individual's condition changes over time. Services which have been based upon incomplete, missing or outdated assessments or Individual Service Plans shall be denied reimbursement. Coordination with case managers and primary care providers is also required.

Providers of Level B residential treatment services, called Therapeutic Behavioral Services for Children and Adolescents, must be licensed by DBHDS. Service authorization is required for all Level B services before the services will be reimbursed. Service-specific provider assessments and Individual Service Plans must be developed, appropriately reviewed, signed/dated, and must be kept up to date as the individual's condition changes over time. Services which have been based upon incomplete, missing or outdated assessments or Individual Service Plans shall be denied reimbursement. Coordination with case managers and primary care providers is also required.

12 VAC 30-60-143 sets out the utilization review requirements, for the purpose of claiming Medicaid reimbursement, applicable to day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, case management (relative to the populations reflected at 12 VAC 30-50-420 and 12 VAC 30-50-430), intensive community treatment for adults, crisis stabilization, and mental health support services (the services defined in 12 VAC 30-50-226). Providers of all services are required to secure and maintain a DMAS provider enrollment agreement. Providers of these community mental health services must collaborate with case management providers, if there is one, in sharing individual status information. Types of licensed professionals who may perform these services, for purposes of Medicaid reimbursement, are specified. In order to improve the quality of service delivery, provider documentation and supervision requirements are detailed. Providers are restricted by 12 VAC 30-130-2000 marketing limitations in order to protect Medicaid individuals and their families from inappropriate provider marketing activities. Outdated references to the Department of Mental Health, Mental Retardation, and Substances Abuse Services are changed to the current DBHDS.

12 VAC 30-130-2000 contains the agency's requirements and limits for providers' marketing plans and activities. These are required to limit the frequency and manner in which providers approach potential clients and seek to engage such clients in their services. DMAS has been made aware that some providers may have engaged in questionable and inappropriate marketing tactics in order to boost their Medicaid patient load thereby increasing their Medicaid reimbursements. DMAS must, pursuant to the 42 CFR § 431.51 guarantee of freedom of choice of providers, protect Medicaid individuals and their families from potential coercion to sign up for treatment with certain providers.

12 VAC 30-130-3000 contains the agency's requirements for Independent Clinical Assessments (ICA) and establishes the entities that will be responsible for completing them as the ICA applies to intensive in-home services, therapeutic day treatment, and mental health support services for children and adolescents. After the ICA is conducted, the individual or the parent/legal guardian must be given free choice in selecting a provider of the needed services in conformance with federal freedom of provider choice requirements of 42 CFR § 431.52. Recommendations for services contained in these new ICAs will not be subject to appeal actions. Such recommendations will be issued by independent assessors as employees or subcontractors with CSBs/BHAs or the BHSA and are akin to physician diagnoses which are also not subject to appeal.

In instances when parents/legal guardians want their children/adolescents to receive certain mental health services that are not supported by the results of the ICA, a process is created for the service provider to provide additional documentation, beyond the ICA, to DMAS' service authorization designee for further consideration. Should the parentally requested service be denied, then the parent/legal guardian will have the right to appeal this service denial via the existing client appeals process at 12 VAC 30-110-10 et seq.

This proposed action also allows for a Behavioral Health Services Administrator (BHSA), a new contractor for DMAS, to manage/administer these services. DMAS is currently undergoing a procurement action to permit the contracting out of this function.

The proposed changes are expected to improve the quality of the community-based mental health services provided to Medicaid participants while enabling DMAS to better control its expenditures in this rapidly expanding service area.

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.

The proposed regulations increase provider qualifications, set out assessment components, require an independent assessment, and require providers to be licensed by the appropriate licensing agency. These actions will ensure that providers are qualified, and employ qualified staff, to work with children, adults, and families. Also, assessments and recommendations for services are standardized. Services will be provided that are appropriate to clinical needs.

The disadvantages of these changes are that some persons who previously qualified to provide services and receive Medicaid reimbursement may no longer qualify for Medicaid payments. If this occurs, there may be possible delays in access to care due to the need for a referral to alternative treatment resources. The number of children receiving certain services may decrease as

they are expected to be referred to less intensive services which may reduce the demand for the more intensive, and more highly reimbursed, services.

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.

The Centers for Medicare and Medicaid Services (CMS) does not have standards for provider qualifications or assessments but expects the states to determine these. Therefore, these requirements are not more restrictive than federal standards.

The marketing requirements were developed with input from the affected stakeholder group and are not more restrictive than similar requirements used in other states. The independent clinical assessment requirements were developed in collaboration with affected stakeholder groups.

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.

There are no localities that will be disproportionately impacted as they 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.

The agency/board is seeking comments on the intended regulatory action, including but not limited to 1) ideas to assist in the development of a proposal, 2) the costs and benefits of the alternatives stated in this background document or other alternatives and 3) potential impacts of the regulation. The agency/board is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) 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.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to the Office of Behavioral Health, 600 East Broad Street, Suite 1300, Richmond, Virginia, 23219, (804/786-1002; fax 804/786-1680) and e-mail CMHRS@dmas.virginia.gov.

Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last day of the public comment period. Comments may also be posted on the Regulatory Town Hall comment forum for this action (www.townhall.va.gov).

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 requirements creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source, and (b) a delineation of one-time versus on-going expenditures.	DMAS expects that these regulations may decrease utilization of intensive children's services due to use of less intensive services. DMAS' costs of adding independent clinical assessments will be offset by lower expenditures resulting from more clinically appropriate care which may involve less intensive services. Also, children who have been admitted to the more intensive services will be discharged more quickly to less intensive levels of care.
Projected cost of the *new regulations or changes to existing regulations* on localities.	No impact is expected for localities since local government entities do not render these services.
Description of the individuals, businesses or other entities likely to be affected by the *new regulations or changes to existing regulations*.	Medicaid service providers of community mental health rehabilitative services include both public and private providers.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	In State Fiscal Year 2011, there were 772 providers of community mental health rehabilitative services. DMAS does not retain records about its providers concerning whether or not they meet the definition of a small business.
All projected costs of the *new regulations or changes to existing regulations* for affected individuals, businesses, or other entities. Please be specific and include all costs. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses. Specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.	These regulations require that service providers obtain information from the Community Services Board/BHA prior to initiating three of the services for children. To offset this, the information will assist in the assessment process. Some providers may experience decreased revenue if it is determined that more children do not meet Medicaid service criteria and therefore would not be eligible to receive Community Mental Health Services.
Beneficial impact the regulation is designed to produce.	The regulations are intended to ensure that children and families receive the most clinically appropriate Medicaid mental health service. Medicaid medical record reviews have indicated that less intensive services may have been sufficiently indicated rather than the more intensive, and more costly, services that were rendered.

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.

This action is based upon Chapter 890, Item 297 YY, of the 2011 *Acts of Assembly* giving DMAS authority to make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriate utilization and cost efficiency. DMAS is recommending additional changes, as a result of a review of these affected regulatory sections, to add consistent requirements for all community mental health services to promote the quality of those services.

The changes were developed with input from stakeholders and these actions were determined to best reflect the needed quality improvements. The main changes were for provider qualifications, Independent Clinical Assessments, allowing for a new DMAS contractor (the Behavioral Health Services Administrator), improvements for the process for requesting service authorizations, expansion of agency documentation and supervision standards, and the addition of marketing guidelines. When provider qualifications were changed, the stakeholders considered whether or not to allow current providers to continue to provide Medicaid services. The options considered were: (i) not allowing providers who did not meet the new criteria to render services, (ii) allowing them to continue (be grand-fathered in), or (iii) reviewing individual providers' credentials. The stakeholders recommended a variance process which was used by DMAS for a limited period of time. Through this process, individual providers have submitted their experience and credentials for review by DMAS. Employees who had at least four years' experience could be granted a variance to continue to provide these Medicaid behavioral health services as long as the employees remained with the same provider-employer. This variance process was used temporarily by DMAS but is not provided for in these permanent regulations.

Regulatory flexibility analysis

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.

The need for improvements in the quality of delivered services was mandated in the 2011 Appropriations Act. The identified changes were developed with the input of stakeholders.

Public comment

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

DMAS' Notice of Intended Regulatory Action was published 8/1/2011 in the *Virginia Register*, Volume: 27 Issue: 24, for its public comment period from August 31, 2011, to September 14, 2011. Comments were received from HOPE Inc., and 2 individuals that were unrelated spam comments. The submitted comments of substance were as follows:

Commenter	Comment	Agency response
HOPE Inc	This commenter indicated that The Virginia Independent Clinical Assessment Program (VICAP) is not operating by the best practices as stated in the standard for intensive in home services. It was stated that "Families should be assessed in their natural environment, in the home to get a detailed assessment of the family dynamics as it relates to the clients needs. Without having a full assessment of the family dynamics, the assessment is flawed and not fully developed in the best interest of the client. This will result in a sub-standard recommendation because it does not have all of the essential information." In addition, the question was raised specifically if this was a practice requirement for private agencies and why would this not be the same standard for public agencies?	The independent clinical assessment is intended to evaluate and identify treatment needs and appropriate services for the child's family. The service provider will continue to conduct a comprehensive assessment in the home. The Agency does not set different standards for private versus public providers. Expectations for the Independent Clinical Assessments are included in the contract established with the Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs).

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; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease

disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

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.*

This proposed regulatory stage is not the same as the previously approved emergency regulations on this subject. The differences are: (i) the emergency regulations required that the new Independent Clinical Assessments be performed for both Level A services (Community Based Services for Children and Adolescents in 12 VAC 30-50-130) and Level B services (Therapeutic Behavioral Services in 12 VAC 30-50-130)—the proposed regulations eliminated this requirement for these two services but retained it for IIH, TDT and MHSS; (ii) these proposed stage regulations require that entities that are licensed by DBHDS have full annual, triennial, or conditional licenses and prohibits provisional licenses; (iii) these proposed regulations remove case management as a component of Intensive Community Treatment consistent with federal requirements and change it to care coordination; (iv) provider documentation and staff supervision standards are detailed and reference is made to payment retractions when standards are not met; (v) provider service standards are stated that must be met in order to avoid payment retractions; (vi) a new section of general applicability is proposed for Chapter 60; (vii) the proposed regulations recognize the establishment of a Behavioral Health Benefits Administrator which DMAS intends to contract out, via the Commonwealth's procurement process, in order to better manage the use of these services. The proposed Marketing Requirements and Restrictions are the same as those in the previous emergency stage regulations. Technical, editorial changes are made to improve readability.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
12 VAC 30-50-130		Sets out the amount, duration, and scope of community mental health services covered for children and adolescents under the authority of EPSDT. These services are: intensive in-home; therapeutic day treatment; community-based services (Level A); therapeutic behavioral services (Level B). Intensive In-	Definitions are added. Professional personnel definitions correlate to licensing standards established by DBHDS, DSS or DOJ, as appropriate for the provider type. Provisional licenses will no longer be permitted. Prior authorization, before the onset of any of these services, is proposed. Standards are proposed for frequency of psychoeducational services; cases failing the standard will have payments retracted. When an individual no longer needs the required

		Home (IIH) services were covered for an initial period before a prior authorization had to be obtained. QMHPs with specific years of experience were permitted to render counseling services. Provider provisional licenses are permitted. Clinical experience did not require that internships, practicums, and field experience had to be supervised. Case management is a component of IIH and Intensive Community Treatment (ICT).	amount of psychoeducational services, he is to be moved to a less intensive level of care. Care coordination between different providers is required and must be documented. DBHDS agency name is updated. Case management is being removed from IIH and ICT due to 42CFR § 441.18 that prohibits case management from being a direct service. Service definition was revised to provide for care coordination which is less comprehensive than case management.
12 VAC 30-50-226		Sets out the amount, duration, and scope of community mental health services covered for both children and adults. These services are: day treatment/partial hospitalization; psychosocial rehabilitation; crisis services; intensive community treatment; crisis stabilization, and; mental health supports. QMHPs with specific years of experience are permitted to render counseling services. Case management is a component of IIH and Intensive Community Treatment (ICT).	Definitions are added to require professionals to meet licensing standards required by DBHDS in order to claim Title XIX reimbursement. Professional personnel definitions correlate to licensing standards established by DBHDS, DSS or DOJ, as appropriate for the provider type. Specific licensing types of professionals are proposed which may render these services for the purpose of claiming Medicaid reimbursement. Outdated reference to mental retardation is changed to intellectual disability due to federal law change. Service-specific provider assessments are proposed to support providers' claims for these services. Case management is being removed from IIH and ICT due to 42CFR § 441.18 that prohibits case management from being a direct service. Service definition was revised to provide for care coordination.
	12 VAC 30-60-5	New section.	Provides for general applicability of certain utilization review requirements for all Medicaid covered services. Provisional licenses prohibited. DBHDS' full annual, triennial or conditional license required of

			providers as well as DMAS provider enrollment agreement. Expenditure recoveries permitted when providers' documentation does not support claim(s) filed.
12 VAC 30-60-61		Specific assessment data elements are not required for IIH, Therapeutic Day Treatment and residential Levels A/B. The place of the assessment and the face to face requirement for IIH was not included. QMHPs are allowed to conduct assessments with a review by licensed MH professional for IIH and Therapeutic Day Treatment. Regs did not contain any caseload standards or supervision requirements for IIH or Therapeutic Day Treatment. No marketing guidelines existed. Definition of LMHP limited the number of licensed professionals that can render services for XIX reimbursement. No notification requirements for case managers or primary care providers. No provisions for service authorizations when lapses in services occurs.	Specific assessment data elements are proposed to ensure uniform and complete assessments. The place of the conduct of the IIH assessment must be in the home in order to evaluate family dynamics. LMHPs will be required to conduct IIH/Therapeutic Day Treatment assessments due to the acute nature of the service. DMAS is proposing to adopt the DBHDS licensing standards to promote improved quality of service delivery. Proposed marketing guidelines are intended to reduce/preclude inappropriate marketing activities by potential providers. Definition of LMHP was expanded to include the licensing board's standards for purposes of Title XIX reimbursement. Requirements are added for service notifications to case managers and primary care providers. Provision is made for service authorizations when temporary lapses of services occurs. Specific prohibition is proposed against providers copying the same progress notes from day to day. Provider documentation and supervision requirements are established to avoid payment retractions. Applicability of marketing restrictions established.
12 VAC 30-60-143		Providers must meet federal/state requirements for administrative and financial management capacity. Providers must document and maintain individual case records in accordance with requirements. Provider has to ensure free choice of providers to Medicaid individuals.	Service-specific provider assessments to be completed by certain professional license levels. Professionals who must periodically review the individual's Individual Service Plan are expanded by licensing type. Providers prohibited from copying previous progress notes to new dates of service and using generic suggested language published in publicly available publications. Provider documentation and supervision requirements are established to avoid payment retractions. Providers must comply with marketing restrictions and requirements. Coordination with case manager and primary care provider is proposed.
	12 VAC 30-130-2000	N/A	Rules are intended to control how providers will be permitted to market their services to potential Medicaid clients. Provid-

			ers must secure DMAS' prior approval of marketing plans and can only distribute marketing literature to localities as permitted by their DBHDS' license. Providers may not offer money or non-monetary incentives to entice Medicaid clients into their caseloads or to retain them. Providers are specifically prohibited from using Medicaid clients' Protected Health Information to identify or market services. Providers are specifically prohibited from violating confidentiality of Medicaid clients' information. Providers are prohibited from conducting service assessment activities at health fairs or other types of community events. Providers are prohibited from asserting that they are endorsed by Medicaid or any federal entity. Providers violating restrictions will be subject to the termination of their provider contracts for the services affected by the marketing activity or violation.
		N/A	New rules establish requirements and applicability of the Independent Clinical Assessment (ICA). In the absence of an ICA for designated services, those services will not be reimbursed.