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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(s)** | 12 VAC 30-50-130; 12VAC30-60-25; 12VAC30-70-201, 70-321, 70-415 and 70-417; 12VAC30-80-21; 12VAC30-130-850 through 890 |
| **Regulation title(s)** | Amount, Duration, and Scope of Medical and Remedial Care and Services Provided for Categorically and Medically Needy Recipients; Standards Established and Methods Used to Assure High Quality of Care; Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services and -Other Types of Providers; Residential Psychiatric Treatment for Children and Adolescents |
| **Action title** | Institutions for Mental Disease Reimbursement Changes |
| **Date this document prepared** | May 14, 2015 |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

## Brief summary

*Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.*

As the result of a court decision, DMAS has been required to change the requirements for inpatient psychiatric facilities (IPFs) and for providers who offer certain services (such as physician services, medical and psychologic services, vision, dental and emergency services) to residents of IPFs. The affected IPFs are freestanding psychiatric hospitals (both state hospitals and private hospitals) and residential treatment facilities (Level C). In order for these services to continue to be reimbursed separately from the per-diem rate paid to IPFs, the Centers for

Medicare and Medicaid Services (CMS) requires that the IPF: 1) arrange for and oversee the provision of all services; 2) maintain all medical records of services provided under arrangement furnished to the member residing in the IPF; 3) ensure that each member residing in an IPF has a comprehensive plan of care that includes services provided under arrangement; and 4) ensure that all services, including services provided under arrangement, are furnished under the direction of a physician. If these requirements are not met, DMAS will not reimburse for these services and providers may not charge members directly.

## Legal basis

*Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.*

For the preceding emergency regulations, DMAS acted based upon the 2012 *Acts of the Assembly*, Chapter 3, in which Item 307 CCC directed the agency to develop changes to requirements for non-facility services furnished to individuals residing in institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) in order to comply with federal law. The 2013 *Acts of the Assembly*, Chapter 806, Item 307 CCC directed the agency to require that institutions of mental diseases provide referral services to their inpatients when the inpatients need services and to document such referrals and receipt of non-facility services.

Additionally, the emergency regulatory authority came from the 2014 *Acts of the Assembly*, Chapter 3, in which Item 301 XX directed the agency to revise reimbursement for services furnished Medicaid members in residential treatment centers and freestanding psychiatric hospitals to include professional, pharmacy and other services to be reimbursed separately as long as the services are in the plan of care developed by the residential treatment center or the freestanding psychiatric hospital and arranged by the residential treatment center or the freestanding psychiatric hospital. The same authority exists in the 2015 *Acts of the Assembly*, Chapter 665, Item 301 XX.

The authority for this proposed stage regulation (which follows the emergency regulation) is the *Code of Virginia* (1950) as amended, § 32.1-325, which 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 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.

## Purpose

*Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.*

The US Department of Health and Human Services Office of Inspector General (OIG) audited DMAS' claims for non-facility furnished to individuals younger than 21 years of age who reside in Inpatient Psychiatric Facilities (IPFs) and issued its report on March 17, 2004. The report concluded that DMAS must refund to CMS $3.9 million for disallowed claims (mostly physician and pharmacy claims) for services furnished to children who resided in IPFs between July 1, 1997 through June 30, 2001 because these services were not part of the allowable inpatient psychiatric benefit. These services were not included in the reimbursement rates for the IPFs but were billed and paid separately to other providers of services.

Based on the OIG report, CMS issued a disallowance on February 29, 2008. DMAS appealed the CMS disallowance but each appeal was denied resulting in a final decision being issued by the U.S. Court of Appeals on May 8, 2012.

In response to that decision, and in accordance with CMS' guidance on the inpatient psychiatric benefit, DMAS implemented emergency regulations to permit separate billing for services (referred to by CMS and in the regulations as "services provided under arrangement") when rendered to members under age 21 in IPFs when the IPF: i) arranges for and oversees the provision of all services, including services furnished through contracted providers; ii) maintains all records of medical care furnished to these individuals; and iii) ensures that all services are furnished under the direction of a physician.

DMAS will continue to enforce the requirement that written plans of care for individuals in IPFs be comprehensive, covering medical, psychological, social, behavioral and developmental needs (including emergency services). In addition, both the emergency regulations that are currently in effect, as well as these proposed regulations will require IPFs to: i) contract with non-employee providers of services under arrangement (to the extent non-employee providers are providing services under arrangement); ii) make referrals to employee and contracted providers of services provided under arrangement; iii) obtain and maintain medical records from all providers of services provided under arrangement that are not covered by the facility's per diem.

If these requirements are met, DMAS will continue to directly reimburse providers of services under arrangement using existing reimbursement methodologies. If these requirements are not met, both the emergency regulations that are currently in effect as well as these proposed stage regulations establish detailed criteria for audits that will result in retractions of reimbursement.

## Substance

*Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.*

The sections of the State Plan for Medical Assistance that are affected by this action are: the Amount, Duration, and Scope of Medical and Remedial Services Provided to Categorically/Medically Needy Individuals-EPSDT Services (12 VAC 30-50-130); Standards Established and Methods Used to Assure High Quality of Care (Utilization control: freestanding psychiatric hospitals (12VAC30-60-25)); Methods and Standards for Establishing Payment Rates—Inpatient Hospital Services (12VAC30-70-201, 12 VAC 30-70-321, 12 VAC 30-70-415, and 12 VAC 30-70-417) and -Other Types of Providers (inpatient psychiatric services in residential treatment facilities (under EPSDT (12VAC30-80-21)). The state-only regulations that are affected by this action are Residential Psychiatric Treatment for Children and Adolescents (plans of care; review of plans of care (12VAC30-130-850 through 130-890).

Prior to the effective date of the emergency regulations, DMAS paid separately for professional services, such as physician or pharmacy services, that were furnished in facilities (hospitals, nursing facilities, residential treatment centers, etc.) to inpatients or residents. At that time, each provider was only required to maintain records for the services they furnished directly. The facilities (hospitals, nursing facilities, residential treatment centers) were not required to make referrals for or maintain results of these services.

When a child is in an Inpatient Psychiatric Facility (either freestanding public/private psychiatric hospitals or residential treatment centers), under CMS' interpretation as a result of the referenced court order, these separate payments to the providers of professional services and for drugs are not eligible for federal Medicaid matching funds unless the services are part of the inpatient psychiatric benefit. To be part of the inpatient psychiatric benefit and eligible for federal Medicaid matching funds, the IPF must oversee and arrange for these services, maintain the medical records of care furnished to these individuals and insure that services are furnished under the direction of a physician. If these requirements are met, DMAS may continue to directly reimburse providers of services under arrangement using existing reimbursement methodologies.

Certain services are already covered by these facilities' per diem payments. Therefore, the list of services provided under arrangement affected by this proposed regulation varies by each facility type (state freestanding psychiatric hospital, private freestanding psychiatric hospital, and residential treatment center).

The following chart lists the services provided under arrangement that may be billed separately for each provider type, provided that the requirements discussed above are met. No other services may be billed for members under age 21 residing in IPFs.

| Services Provided Under Arrangement | Residential Treatment Centers Level C | Private Freestanding Psychiatric Hospitals | State Freestanding Psychiatric Hospitals |
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| Physician Services | Yes | Yes | No |
| Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory | Yes | Yes | No |

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| therapists, substance abuse treatment practitioners) | | | |
| Outpatient Hospital Services | Yes | Yes | No |
| Pharmacy services | Yes | No | Yes |
| Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders | Yes | Yes | No |
| Services Provided Under Arrangement | Residential Treatment Centers Level C | Private Freestanding Psychiatric Hospitals | State Freestanding Psychiatric Hospitals |
| Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies) | Yes | No | No |
| Vision services | Yes | Yes | No |
| Dental and orthodontic services | Yes | Yes | No |
| Non-Emergency Transportation services | Yes | Yes | No |
| Emergency services (including outpatient hospital, physician and transportation services) | Yes | Yes | Yes |

## 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 there are no disadvantages to the public or the Commonwealth, please indicate.*

There are no advantages or disadvantages to private citizens in these changes. The primary advantages to the agency and the Commonwealth is that these changes will comport with federal requirements as a result of the lawsuit discussed above. These changes could be seen as a disadvantage to Institutions of Mental Disease and providers of services under arrangement because of these additional referral and service documentation requirements but the changes are necessary to continue to use Medicaid funds to reimburse for these services.

## Requirements more restrictive than federal

*Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need 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.*

There are no requirements more restrictive than federal requirements. All of these changes are the result of federal requirements as discussed above.

## 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 affected more than any others. These changes are to be applied uniformly 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.*

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.

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 William Lessard, Director, Division of Provider Reimbursement, DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219; William.Lessard@dmas.virginia.gov ; (804) 225.4593; fax (804) 786-1680**.** 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.*

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| **Projected cost to the state to implement and enforce the proposed regulation, including:**<br>**a) fund source / fund detail; and**<br>**b) a delineation of one-time versus on-going expenditures** | DMAS costs include claims processing computer system changes and provider training. |
| **Projected cost of the new regulations or changes to existing regulations on localities.** | There are no costs to localities. |
| **Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.** | There are approximately 21 residential treatment centers, 6 private psychiatric hospitals and 2 state facilities serving members under the age of 21 that will be affected. There are numerous providers of services under arrangement (physicians, psychologists, pharmacies, outpatient |

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| | hospitals, dentists, etc.). |
| **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:<br>a) is independently owned and operated and;<br>b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million. | The agency assumes that most of these entities are small businesses except for the hospitals. |
| **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 including:**<br>**a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and**<br>**b) 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.** | Providers to a great degree already follow many of these requirements but do not formally document them or physically share medical records. DMAS cannot estimate these costs but believe they will be minor. |
| **Beneficial impact the regulation is designed to produce.** | Compliance with federal law is necessary for the federal government to continue to pay 50% of the costs. |

## 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.*

The result of the lawsuit discussed above required DMAS to make a change. DMAS considered paying an all-inclusive rate to the IMDs, but DMAS felt that the financial risk would be too great for the IMD to pay for any service needed by a member. DMAS considered a mixed approach (an all-inclusive rate for some of the routine services and the proposed approach for the non-routine services) but felt that it would be too complicated. The proposed approach results in the least disruption to the current approach that directly reimburses providers for services that are furnished to individuals who reside in IMDs.

## 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.*

The only feasible alternative would have been to pay an all-inclusive rate to the IMDs, but DMAS felt that the financial risk would be too great for the IMD to pay for any service needed by a member. DMAS considered a mixed approach (an all-inclusive rate for some of the routine services and the proposed approach for the non-routine services) but felt that it would be too complicated. The proposed approach results in the least disruption to the current approach that directly reimburses providers for services that are furnished to individuals who reside in IMDs.

## 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; nor 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.

## Public comment

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

DMAS published its Notice of Intended Regulatory Action in the Virginia Register dated 6/2/2014 (VR 30-20). Comments were received from the Virginia Hospital and Healthcare Association as follows:

| Commenter | Comment | Agency response |
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| VHHA | 1. 12 VAC 30-60-25: the one day requirement that comprehensive plans of care include all services is unrealistic and unneces-sary. Commercial payers typically require 30 days. | 1. The one day requirement has been modified to three days. |
| | 2. VHHA members have indicated problems with executing contracts with | 2. DMAS will communicate to providers of services under arrangement that contracting is necessary in order to be |

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| | providers because they state that they do not know enough about the contractual terms sought by the IMD.<br><br>3. 12 VAC 30-130-890: Two sections appear to contradict each other. This section appears to permit flexibility in payment denials or retractions for residential treatment centers. If this is permitted, why is this not provided for in the sections (12 VAC 30-60-25) concerning inpatient psychiatric facilities?<br>4. The Medicaid Memo has contradictory guidance whether providers of services under arrangement have to be Medicaid enrolled providers. | reimbursed. No regulatory changes are needed.<br><br>3. Section 25 has been rewritten to parallel language in section 890.<br><br>4. In order for DMAS to pay for services provided under arrangement, the provider of a service under arrangement must be a Medicaid enrolled provider. However, regulations do not prevent the IPF from arranging for services in the plan of care using a Medicaid non-enrolled provider. |
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Further comments were provided, concerning the DMAS Medicaid Memo on this subject, which are not directly relevant to this regulatory action.

## Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. 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, rationale, and likely impact of proposed requirements |
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| 12VAC 30-50-130 | | Under the emergency regulations that are currently in place, text requires IPFs to arrange for and maintain records of care furnished by outside providers and ensure | Changes between emergency and proposed stage:<br>• In 30-50-130(B)(5)(d) and (e) the following phrase was added: "pursuant to 42 CFR 440.130." This phrase was added after discussions with CMS, in |

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| | | that the services provided under arrangement and are included in the plan of care. | order to meet CMS requirements.<br>• In 30-50-130(B)(6) was restructured to create three subsections (i, ii, and iii) to increase clarity.<br>• In 30-50-130(B)(6)(b)(3), the phrase "as defined at 42 CFR 483.352" was added. This phrase was added after discussions with CMS, in order to meet CMS requirements.<br>• In 30-50-130(B)(6)(b)(2), outpatient hospital services were added as item (ii) to include all services mentioned in the 6-9-14 Medicaid Memo on the changes.<br>• In 30-50-130(B)(6)(b)(3), pharmacy services were added as item (ii), outpatient hospital services were added as item (iii) and durable medical equipment was added as item (vi). These changes were made to include all services mentioned in the 6-9-14 Medicaid Memo.<br>• In 30-50-130(B)(6)(c), the phrases "the Code of Federal Regulations" and "specifically" and "the Conditions of Participation in 42 CFR Part 483 Supbpart G" were added. These phrases were added after discussions with CMS, in order to meet CMS requirements.<br>• In 30-50-130(B)(6)(d) the following sentence was added: "Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT." This sentence was added after discussions with CMS, in order to meet CMS requirements. |
| 12VAC 30-60-25 | | Under the emergency regulations that are currently in place, new plan of care requirements are established. The regulations establish the specific requirements for freestanding psychiatric hospitals, the time frames under which the requirements must be met, and how non-compliance will be addressed during audits. | Changes between emergency and proposed stage:<br>• In 30-60-25(C) the following sentence was added: "All Medicaid services are subject to utilization review/audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement." This sentence was added to clarify requirements.<br>• In 30-60-25(C)(4), the phrase "written contractual" was added to the first sentence to clarify and to meet CMS requirements.<br>• In 30-60-25((H)(7)(a), one business day was changed to three business days in response to a public comment that was received. (See public comment section, |

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| | | | above.) |
| 12VAC 30-70-201 | | Under the emergency regulations that are currently in place, all services provided under arrangement can be billed separately only if they are included in the plan of care; if they are arranged and overseen by the freestanding psychiatric hospital; and if the medical records for such services are maintained by the freestanding psychiatric hospital in the individual's medical record. | No changes between emergency and proposed stages. |
| 12VAC 30-70-321 | | Under the emergency regulations that are currently in place, the sections related to billing of services provided under arrangement were moved to a new section, 30-70-415. | No changes between emergency and proposed stages. |
| 12VAC 30-70-415 | | Under the emergency regulations that are currently in place, all services provided under arrangement to freestanding psychiatric hospital patients can be billed separately only if they are included in the plan of care; if they are arranged and overseen by the freestanding psychiatric hospital; if the medical records for such services are maintained by the freestanding psychiatric hospital in the individual's medical record; and if the services are ordered by a physician. | No changes between emergency and proposed stages. |
| 12VAC 30-70-417 | | Under the emergency regulations that are currently in place, all services provided under arrangement to RTC residents may be billed separately only if they are included in the plan of care; if they are arranged and overseen by the RTC; if the medical records for such services are maintained by the RTC in the individual's medical record, and ; if the services are ordered by a physician. | No changes between emergency and proposed stages. |

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| 12VAC 30-80-21 | | Under the emergency regulations that are currently in place, billing for services furnished under arrangement in an inpatient psychiatric facility are subject to special rules in 30-70-415 and 417. | Changes between emergency and proposed stage:<br>• In 30-80-21, the following underlined phrase was added: "Reimbursement for all services furnished to individuals younger than 21 years of age who are …"<br>• In 30-80-21, the following underlined phrase was removed: "… and reimbursement of services provided under arrangement described in 12VAC30-80 or elsewhere in the state plan."<br>Both changes were made to clarify requirements. |
| 12VAC 30-130-850 through 890 | | Under the emergency regulations that are currently in place, the plan of care includes a list of services provided under arrangement, the prescribed frequency of treatment, and the circumstances under which treatment shall be sought. The regulations establish specific requirements for RTCs, the timeframes under which requirements must be met, and how non-compliance will be addressed during audit. | Changes between emergency and proposed stage:<br>• In 30-130-850, definitions were added for "individual or individuals" and "inpatient psychiatric facility" and for "services provided under arrangement." These changes were made to add clarity to the regulations.<br>• In 30-130-890, a new section (A) was added to clarify requirements.<br>• In 30-130-890, the word "recipient" was changed to "individual" to add consistency to the regulations.<br>• In 30-130-890(H), the first sentence was stricken, as the content was moved to the new section A.<br>• Section 30-130-890(H) was restructured and renumbered to provide clarity.<br>• The text in Section 30-130-890(H)(6) was added to clarify requirements.<br>• In Section 30-130-890(L), the word "child" was changed to "individual" to add consistency to the regulations.<br>• The text in Section 30-130-890(M) was moved to Section 30-130-890(A). |
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