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Final Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12VAC30-10-540, 12VAC30-30-10, 12VAC30-50-130, 12VAC30-50-226, 12VAC30-50-9999, 12VAC30-60-5, 12VAC30-60-50, 12VAC30-60-61, 12VAC30-130-850, 12VAC30-130-860, 12VAC30-130-870, 12VAC30-130-880, 12VAC30-130-890; 12VAC30-130-3000, 12VAC30-130-3020
Regulation title(s)	Residential Treatment Services Emergency Regulations: Amount, Duration and Scope of Medical and Remedial Services; and Standards Established and Methods Used to Assure High Quality of Care
Action title	Psychiatric Residential Treatment 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 Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations.*

Brief Summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The DMAS psychiatric residential treatment service was implemented in 2001 and the associated regulations have not been updated since then. The existing regulations are not adequate to ensure successful treatment outcomes are attained for the individuals who receive high cost high intensity residential treatment services. Since moving behavioral health services to Magellan (the DMAS Behavioral Health Service Administrator, or BHSA) there has been enhanced supervision of these services. The enhanced supervision has led to an increased awareness of some safety challenges

and administrative challenges in this high level of care. The proposed revisions will serve to better clarify policy interpretations that revise program standards to allow for more evidence based service delivery, allow DMAS to implement more effective utilization management, enhance individualized coordination of care, implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, and support DMAS audit practices. The changes will move toward a service model that will reduce lengths of stay and facilitate an evidence based treatment approach to better support the individual's discharge into their home environment. These changes also align DMAS in meeting the requirements set forth by the Centers for Medicare and Medicaid Services (CMS) in 42CFR 441 Subpart D and 42CFR 441.453.

The final stage action regulatory text is the same as the text at the proposed stage.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

BHA = Behavioral Health Authority
BHSA = Behavioral Health Services Administrator
CMS = Centers for Medicare and Medicaid Services
CSA = Comprehensive Services Act
CSB = Community Services Board
DBHDS = Department of Behavioral Health and Developmental Services
DMAS = Department of Medical Assistance Services
DOJ = Department of Justice
EPSDT = Early Periodic Screening, Diagnosis, and Treatment
FAPT = Family Assessment and Planning Team
FFP = Federal Financial Participation
FFS = Fee for Service
ICF/ID = Intermediate Care Facility for the Intellectually Disabled
ICF/MR = Intermediate Care Facility for the Mentally Retarded
IMD = Institution for Mental Disease
MCO = Managed Care Organization
MDT = Multi-Disciplinary Treatment Team

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary entitled "Psychiatric Residential Treatment Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications" and adopt the action stated therein. I certify that this final regulatory action has

completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

_____ _____

Date

Jennifer S. Lee, M.D., Director

Dept. of Medical Assistance Services

Mandate and Impetus

Please list all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously-reported information, include a specific statement to that effect.

There are no changes to the information reported at the proposed stage.

DMAS is submitting this regulatory action to comply with Chapter 665 Item 301.PP of the 2015 *Acts of Assembly* which states:

"The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate 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 shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."

Legal Basis

Please identify (1) the agency or other promulgating entity, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts of Assembly chapter number(s), if applicable. Your citation must 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 or promulgating entity's overall regulatory authority.

Section 32.1-325 of the Code of Virginia authorizes the Board of Medical Assistance Services to administer and amend the State Plan for Medical Assistance and to promulgate regulations. Section 32.1-324 of the Code of Virginia authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the State Plan for Medical Assistance and to promulgate regulations according to the Board's requirements. The Medicaid authority as

established by § 1902 (a) of the Social Security Act (42 USC § 1396a) provides governing authority for payments for services.

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Purpose

Please explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

This regulatory action is essential to protect the health, safety, or welfare of Medicaid-covered individuals who require behavioral health services and their families to ensure that: they are well informed about their behavioral health condition and service options prior to receiving these services; the services are medically necessary; and the services are rendered by providers who use evidence based treatment approaches.

When residential treatment services were implemented by DMAS, individuals did not have access to standardized methods of effective care coordination upon entry into residential treatment due to placement processes at the time and DMAS reimbursement limitations. This resulted in a fragmented coordination approach for these individuals who were at risk for high levels of care and remained at risk of repeated placements at this level of care. Also, at the time of the Appropriations Act mandate, the process in place for Medicaid enrolled children placed in Residential settings yielded an average stay of 260 days – with high readmissions rates.

While residential treatment is not a service that should be approved with great frequency for a large number of individuals it is a service that should be accessible to the families and individuals who require that level of care. The service model had significant operational layers to be navigated to access residential services. The processes involved coordination of care by local FAPT teams who have, over time, demonstrated some influence on determining an individual's eligibility for FAPT funded services. The local influence on the programs administration caused limitations on individualized freedom of provider choice and inconsistent authorization of funding for persons deemed to need psychiatric care out of the home setting. This local administration of the primary referral source for residential treatment was outside the purview of DMAS and this situation produced outcomes that are inadequate to meet CMS requirements on ensuring the individual freedom of choice of providers.

Also of significant importance, the State rules on FAPT composition were not consistent with the federal Medicaid requirement for certifying a child for a Medicaid-funded residential treatment placement. Changes to the program were necessary to address concerns that arose from the reliance upon the FAPT to fulfill the role as the federally mandated independent team to certify residential treatment.

The residential treatment model requires an enhanced care coordination model to support the individuals who receive this level of service to ensure an effective return to the family or caregiver home environment with follow up services to facilitate ongoing treatment progress in the least restrictive environment. The added coordination is required to navigate a very complex service environment for the individual as they return to a community setting to establish an effective aftercare environment that involves service providers who may be contracted with a variety of entities such as DMAS contracted MCO's, enrolled providers, the local FAPT team, local school divisions and the local CSB. This regulation allows DMAS to implement a contracted care coordination team to focus on attaining specific clinical outcomes for all residential care episodes and to provide a single liaison that will ensure coordination of care in a complex service environment for individuals upon discharge from residential treatment and prior to the time when they will enroll in an MCO. (During this transition period the individual is very vulnerable to repeated admissions to residential or inpatient care and must be supported in the FFS environment with resources from the local CSB and enrolled service providers, and requires ongoing support and coordination to receive post discharge follow up and transition services.)

DMAS' goal is that individuals receive the correct level of service at the correct time for the treatment (service) needs related to the individual's medical/psychiatric condition. Residential Treatment services consist of behavioral health interventions and are intended to provide high intensity clinical treatment that should be provided for a short duration. Stakeholders' feedback supported DMAS' observations of lengthy durations of stay for many individuals. Residential treatment services will benefit from clarification of the service definition and eligibility requirements, to ensure that residential treatment does not evolve into a long term level of support instead of the high intensity psychiatric treatment modality that defines this level of care.

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.

This final regulatory action contains the changes made at the emergency and proposed stages in the following areas: (i) provider qualifications including acceptable licensing standards; (ii) pre-admission assessment requirements, (iii) program requirements, (iv) discharge planning and care coordination and; (iv) language enhancements for utilization review requirements to clarify program requirements, ensure adequate documentation of service delivery, and help providers avoid payment retractions. These changes are part of a review of the services to ensure that they are effectively delivered and utilized for individuals who meet the medical necessity criteria. For each individual seeking residential treatment their treatment needs are assessed with enhanced requirements by the current Independent Certification Teams who must coordinate clinical assessment information and assess local resources for each person requesting residential care to

determine an appropriate level of care. The certification teams are also better able to coordinate referrals for care to determine, in accordance with DOJ requirements, whether or not the individual seeking services can be safely served using community based services in the least restrictive setting. Independent Team Certifications are conducted prior to the onset of specified services as required by CMS guidelines.

This regulatory package includes changes to program requirements that ensure effective levels of care coordination and discharge planning occurs for each individual during their residential stay by enhancing program rules and utilization management principles that facilitate effective discharge planning, family engagement and establish community-based services prior to the individual's discharge from residential care. The proposal requires enhanced care coordination to provide the necessary, objective evaluations of treatment progress and to facilitate evidence based practices during the treatment to reduce the length of stay by ensuring that medical necessity indicates the correct level of care and that appropriate and effective care is delivered in a person centered manner. The proposal requires that service providers and local systems will use standardized preadmission and discharge processes to ensure effective services are delivered.

Issues

Please identify the issues associated with the regulatory change, 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, include a specific statement to that effect.

The primary advantages of these regulations to the Commonwealth and to Medicaid members are that they: (i) better clarify policy interpretations that revise program standards to allow for more evidence based service delivery, (ii) allow DMAS to implement more effective utilization management, (iii) enhance individualized coordination of care, implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, (iv) support DMAS audit practices, and (v) move toward a service model that will reduce lengths of stay and facilitate an evidence based treatment approach to better support the individual's discharge into their home environment.

There are no disadvantages to the Commonwealth or the public as a result of these regulations.

Requirements More Restrictive than Federal

Please list all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously-reported information, include a specific statement to that effect.

There are no changes to the previously-reported information: there are no requirements in this regulation that are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Please list all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously-reported information, include a specific statement to that effect.

There are no changes to the previously-reported information: no agencies, localities, or other entities will be particularly affected by these regulations, as the changes apply statewide.

Public Comment

Please summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Ensure to include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency or board. If no comment was received, enter a specific statement to that effect.

Commenter	Comment	Agency response

OR:

No comments were received during the public comment period.

Detail of Changes Made Since the Previous Stage

*Please list all changes that made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Please put an asterisk next to any substantive changes.*

No changes have been made to the regulatory text. The text is identical to that in the proposed stage.