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MEMORANDUM

TO: EMILY MCCLELLAN
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Department of Medical Assistance Services

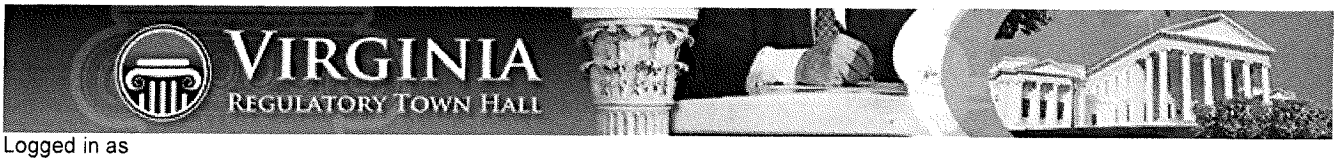
FROM: ELIZABETH M. GUGGENHEIM
Assistant Attorney General

DATE: November 30, 2016

SUBJECT: Fast Track regulations regarding Addiction Recovery Treatment Services (ARTS)

I have reviewed the attached proposed regulations, which would create a new program, Addiction and Recovery Treatment Services (ARTS), which would provide a comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Based on that review, it is my view that the Director, acting on behalf of the Board pursuant to Virginia Code § 32.1-324, and with the authority provided for by Item 306 MMMM of Chapter 780 of the *2016 Acts of the Assembly* and Virginia Code § 32.1-325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Please be aware that this review is based solely upon whether DMAS has the legal authority to promulgate these regulations, not the appropriateness of whether it should be promulgated pursuant to the fast track process. Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either House of the General Assembly or of the Joint Commission on Administrative Rules, the Department of Medical Assistance Services shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the fast-track regulations serving as the Notice of Intended Regulatory Action.



Proposed Text

Action: Addiction and Recovery Treatment (ARTS) Services

Stage: Fast-Track 11/30/16 12:32 PM [latest]

Part III
Amount, Duration and Scope of Services

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION

12VAC30-50-100. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; enrolled providers.

A. Preauthorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and freestanding psychiatric hospitals. Nonauthorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS). Preauthorization shall be based on criteria specified by DMAS. In conjunction with preauthorization, an appropriate length of stay will be assigned using the HCIA, Inc., Length of Stay by Diagnosis and Operation, Southern Region, 1996, as guidelines.

1. Admission review.

a. Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

b. Unplanned/urgent or emergency admissions. These admissions will be permitted before any prior authorization procedures. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions which have been determined to be appropriate. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

2. Concurrent review shall end for nonpsychiatric claims with dates of admission and services on or after July 1, 1998, with the full implementation of the DRG reimbursement methodology. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued inpatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient from acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

3. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for

these services. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

4. Reconsideration process.

a. Providers requesting reconsideration must do so upon verbal notification of denial.

b. This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewer's findings. If higher level review is not requested, the case will be denied and a denial letter generated to both the provider and recipient identifying appeal rights.

c. If higher level review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS medical support. If higher level review is requested, the authorization request will be held in suspense and referred to DMAS medical support for the last step of reconsideration.

d. DMAS medical support will review all case specific medical information. Medical support shall have two working days to render a decision. If medical support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

5. Appeals process.

a. Recipient appeals. Upon receipt of a denial letter, the recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC30-110, the recipient shall have 30 days from the date of the denial letter to file an appeal.

b. Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be held in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the preauthorization requirements specified in subsection A of this section, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

D. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to life of the mother if the fetus were carried to term.

E. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60-day period. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for nonpsychiatric admissions shall cease with dates of service on or after July 1, 1998.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric hospitals in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent or retrospective review processes described in subsection A of this section. Medically unjustified days in such hospitalizations shall not be authorized for payment.

F. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

G. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

H. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

I. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

J. Addiction and recovery treatment services shall be covered in inpatient facilities consistent with 12 VAC 30-130-5000 et seq.

12VAC30-50-110. Outpatient hospital and rural health clinic services.

A. Outpatient hospital services.

1. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

a. Are furnished to outpatients;

b. Except in the case of nurse-midwife services, as specified in 42 CFR 440.165, are furnished by or under the direction of a physician or dentist; and

c. Are furnished by an institution that:

(1) Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(2) Except in the case of medical supervision of nurse-midwife services, as specified in 42 CFR 440.165, meets the requirements for participation in Medicare.

2. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of life to the mother if the fetus was carried to term.

3. The following limits and requirements shall apply to DMAS coverage of outpatient observation beds.

a. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment.

b. Nonroutine observation for underlying medical complications, as explained in documentation attached to the provider's claim for payment, after surgery or diagnostic services shall be covered. Routine use of an observation bed shall not be covered. Noncovered routine use shall be:

(1) Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services (e.g., services for routine post-operative monitoring during a normal recovery period (four to six hours)).

(2) Observation services provided in conjunction with emergency room services, unless, following the emergency treatment, there are clear medical complications which must be managed by a physician other than the original emergency physician.

(3) Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

c. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient precertification, where applicable.

d. When inpatient admission is required following observation services and prior approval has been obtained for the inpatient stay, observation charges must be combined with the appropriate inpatient admission and be shown on the inpatient claim for payment. Observation bed charges and inpatient hospital charges shall not be reimbursed for the same day.

4. Addiction and recovery treatment services shall be covered in outpatient hospital facilities consistent with 12 VAC **30-130-5000** et seq.

B. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

1. The same service limitations apply to rural health clinics as to all other services.

2. Addiction and recovery treatment services shall be covered in rural health clinics consistent with 12 VAC **30-130-5000** et seq.

C. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

1. The same service limitations apply to FQHCs as to all other services.

2. Addiction and recovery treatment services shall be covered in FQHCs consistent with 12 VAC **30-130-5000** et seq.

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12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services, and family planning.

A. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

5. Community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

a. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and

adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed psychiatric nurse practitioner, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees,

these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the

clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(4) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

c. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

(1) Service authorization shall be required for Medicaid reimbursement.

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

(3) These services may be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

d. Community-based services for children and adolescents under 21 years of age (Level A).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the

industry, such as McKesson InterQual® Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

(9) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(10) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

e. Therapeutic behavioral services (Level B).

(1) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry; such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

(8) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.

(9) These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership.

b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of Amount, Duration and Scope of Selected Services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with 42 CFR Part 441 Subpart D, as contained in 42 CFR 441.151 (a) and (b) and 441.152 through 441.156. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

8. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12 VAC 30-130-5000 et seq.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services.

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D. Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation

shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

D. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION

12VAC30-50-140. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Outpatient psychiatric services.

1. Psychiatric services are limited to an initial availability of 26 sessions, without prior authorization during the first treatment year. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary psychiatric services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.

2. Psychiatric services can be provided by psychiatrists or by a licensed clinical social worker, licensed professional counselor, licensed clinical nurse specialist-psychiatric, or a licensed marriage and family therapist under the direct supervision of a psychiatrist.*

3. Psychological and psychiatric services shall be medically prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by either a psychiatrist or by a licensed psychiatric nurse practitioner, licensed clinical social worker, licensed professional counselor,

licensed clinical nurse specialist-psychiatric, or licensed marriage and family therapist under the direct supervision of a psychiatrist.

4. Psychological or psychiatric services shall be considered appropriate when an individual meets the following criteria:

a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels that have been impaired;

b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities;

c. Is at risk for developing or requires treatment for maladaptive coping strategies; and

d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

5. Psychological or psychiatric services may be provided in an office or a mental health clinic.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of life to the mother if the fetus was carried to term.

G. Physician visits to inpatient hospital patients over the age of 21 are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses or treatment plan and is further restricted to medically necessary authorized (for enrolled providers)/approved (for nonenrolled providers) inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days shall be limited to medically necessary inpatient hospital days.

H. (Reserved.)

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. (Reserved.)

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff

must be recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If prior authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered noncosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated or are intended solely to preserve, restore, confer, or enhance the aesthetic appearance of the breast.

M. Admitting physicians shall comply with the requirements for coverage of out-of-state inpatient hospital services. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the Commonwealth of Virginia shall only be reimbursed under at least one the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is general practice for recipients in a particular locality to use medical resources in another state.

N. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

O. Prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering nonemergency outpatient Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain prior authorization from the Department of Medical Assistance Services (DMAS) for those scans. The servicing provider will not be reimbursed for the scan unless proper prior authorization is obtained from DMAS by the referring physician.

~~P. Outpatient substance abuse treatment services shall be limited to an initial availability of 26 therapy sessions without prior authorization during the first treatment year. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability~~

~~is further restricted to no more than 26 therapy sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse treatment services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.~~

~~1. Outpatient substance abuse services shall be provided by medical doctors or by doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry; or by a physician or doctor of osteopathy who is certified in addiction medicine. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities. Outpatient substance abuse treatment services are further defined in 12VAC30-50-228.~~

~~2. Psychological and psychiatric substance abuse services shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in subdivision 1 of this subsection.~~

~~3. Psychological or psychiatric substance abuse services shall be considered appropriate when an individual meets the criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance-related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria as prescribed in Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R), Second Edition.~~

~~4. Psychological or psychiatric substance abuse services may be provided in an office or a clinic under the direction of a physician.~~

~~*Licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, and licensed marriage and family therapists may also directly enroll or be supervised by psychologists as provided for in 12VAC30-50-150.~~ Addiction and recovery treatment services shall be covered in physician services consistent with 12 VAC 30-130-5000 et seq.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION

12VAC30-50-150. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometrists' services. Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services are not provided.

D. Other practitioners' services; psychological services, psychotherapy. Limits and requirements for covered services are found under Outpatient Psychiatric Services (see 12VAC30-50-140 D).

1. These limitations apply to psychotherapy sessions provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric/licensed marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of 26 sessions without prior authorization. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding treatment year when prior authorized by DMAS or its designee. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

2. Psychological testing is covered when provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric, marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist.

E. ~~Outpatient substance abuse services are limited to an initial availability of 26 sessions without prior authorization during the first treatment year. An additional extension of up to 26 sessions is available during the first treatment year and must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.~~ Addiction and recovery treatment services shall be covered in consistent with 12 VAC 30-130-5000 et seq.

~~1. Outpatient substance abuse services shall be provided by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, a licensed substance abuse treatment practitioner, or an individual who holds a bachelor's degree and certification as a substance abuse counselor (CSAC) who is under the direct supervision of one of the licensed practitioners listed in this section, or an individual who holds a bachelor's degree and is a certified addictions counselor (CAC) who is under the direct supervision of one of the licensed practitioners listed in this section. The provider must also be qualified in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities. Outpatient substance abuse treatment services are further defined in 12VAC30-50-228.~~

~~2. Psychological and psychiatric substance abuse services shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in subdivision 1 of this subsection.~~

~~3. Psychological or psychiatric substance abuse services shall be considered appropriate when an individual meets criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance-related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria as prescribed in Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R), Second Edition.~~

~~4. Psychological or psychiatric substance abuse services may be provided in an office or a clinic~~.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION

12VAC30-50-180. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of life to the mother if the fetus were carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 CFR 440.165, are furnished by or under the direction of a physician or dentist.

C. Reimbursement to community mental health clinics for medical psychotherapy services is provided only when performed by a qualified therapist. For purposes of this section, a qualified therapist is:

1. A licensed physician who has completed three years of post-graduate residency training in psychiatry;

2. An individual licensed by one of the boards administered by the Department of Health Professions to provide medical psychotherapy services including: licensed clinical psychologists, licensed psychiatric nurse practitioners, licensed clinical social workers, licensed professional counselors, clinical nurse specialists-psychiatric, or licensed marriage and family therapists; or

3. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure by one of the appropriate boards as specified in subdivision 2 of this subsection, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in subdivisions 1 and 2 of this subsection.

D. ~~Coverage of community mental health clinics for substance abuse treatment services, as further defined in 12VAC30-50-228, is provided only when performed by a qualified therapist and consistent with an active written plan designed and signature-dated. For purposes of providing this service a qualified therapist shall be:~~

~~1. Physicians and doctors of osteopathy who have completed three years of post-graduate residency training in psychiatry or by a physician or doctor of osteopathy who is certified in addiction medicine.~~

~~2. A licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, or a licensed substance abuse treatment practitioner. The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.~~

~~3. An individual who holds a master's or doctorate degree, who has completed all coursework necessary for licensure by the respective board, and who has applied for a license but has not yet received such license, and who is currently supervised in furtherance of the application for such license, in accordance with requirements or regulations promulgated by DMAS, by one of the licensed practitioners listed in this subsection.~~

~~4. An individual who holds a bachelor's degree in any field and certification as a substance abuse counselor (CSAC) or an individual who holds a bachelor's degree and is a certified addictions counselor (CAC) who is under the direct supervision of one of the licensed practitioners listed in subdivision C 1 or 2 of this subsection.~~ Addiction and recovery treatment services shall be covered in consistent with 12 VAC 30-130-5000 et seq.

12VAC30-50-228. ~~Community substance abuse treatment services.~~ (Repealed.)

~~A. Services to be covered shall include crisis intervention, day treatment services in nonresidential settings, intensive outpatient services, and opioid treatment services. These services shall be rendered to Medicaid recipients consistent with the criteria specified in 12VAC30-60-250. Individuals shall not receive any combination of day treatment, opioid treatment, and intensive outpatient services concurrently. To be reimbursed by Medicaid, covered services shall meet the following definitions:~~

~~1. Emergency (crisis) intervention. This service shall provide immediate substance abuse care, available 24 hours a day, seven days per week, to assist recipients who are experiencing acute dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the recipient or others, and to provide treatment in the context of the least restrictive setting. This service includes therapeutic intervention, stabilization, and referral assistance over the telephone or face-to-face for individuals seeking services for themselves or others. Services are provided in clinics, offices, homes , and other community locations.~~

~~a. An assessment must be conducted to assess the crisis situation. The assessment must document the need for the service.~~

~~b. Crisis intervention activities, limited annually to 180 hours, may include short-term counseling designed to stabilize the recipient, providing access to further immediate assessment and follow-up, and linking the recipient with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, telephone contacts, and face-to-face support or monitoring or other client-related activities for the prevention of institutionalization.~~

~~c. Assessment and counseling may be provided by a Qualified Substance Abuse Professional (QSAP) as defined in 12VAC30-60-180, or a certified prescreener described in 12VAC30-50-226.~~

~~d. Monitoring and face-to-face support may be provided by a QSAP, a certified prescreener, or a paraprofessional. A paraprofessional, as described in 12VAC30-50-226, must be under the supervision of a QSAP and provide services in accordance with a plan of care.~~

~~2. Substance abuse day treatment, intensive outpatient, and opioid treatment services. These services shall include the major psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; or occupational and recreational therapy, or other therapies. Family therapy must be focused on the Medicaid eligible individual. To be reimbursed by Medicaid, these covered services shall meet the following definitions:~~

~~a. Day treatment services shall be provided in a nonresidential setting and shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week to provide a minimum of 20 hours up to a maximum of 30 hours of skilled treatment services per week. This service should be provided to those recipients who do not require the intensive level of care of inpatient or residential services but require more intensive services than outpatient services. Day treatment is the provision of coordinated, intensive, comprehensive, and multidisciplinary treatment to individuals through a combination of diagnostic, medical psychiatric and psychosocial interventions. The maximum annual limit is 1,300 hours. Day treatment services may not be provided concurrently with intensive outpatient services or opioid treatment services.~~

~~b. Intensive outpatient services for recipients are provided in a nonresidential setting and may be scheduled multiple times per week, with a maximum of 19 hours of skilled treatment services per week. This service should be provided to those recipients who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. Intensive outpatient services are provided in a concentrated manner, and generally involve multiple outpatient visits per week over a period of time for individuals requiring stabilization. These services include monitoring and multiple group therapy sessions during the week, and individual and family therapy which are focused on the Medicaid eligible individual. The maximum annual limit is 600 hours. Intensive outpatient services may not be provided concurrently with day treatment services or opioid treatment services.~~

~~c. Opioid treatment means an intervention strategy that combines treatment with the administering or dispensing of opioid agonist treatment medication. An individual specific, physician-ordered dose of medication is administered or dispensed either for detoxification or maintenance treatment. Opioid treatment shall be provided in daily sessions with a maximum of 600 hours per year. Day treatment and intensive outpatient services may not be provided concurrently with opioid treatment. Opioid treatment service covers psychological and psycho-educational services. Medication costs for opioid agonists shall be billed separately. An individual-specific, physician-ordered dose of medication may be administered or dispensed either for detoxification or maintenance treatment.~~

~~d. Staff qualifications for day treatment, intensive outpatient, and opioid treatment services shall be as follows:~~

~~(1) Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.~~

~~(2) A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual ; relapse prevention ; and occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.~~

~~(3) Paraprofessionals must participate in supervision as described in 12VAC30-60-250.~~

~~B. Evaluations required. Prior to initiation of day treatment, intensive outpatient, or opioid treatment services, an evaluation shall be conducted by at least a QSAP. The minimum evaluation will consist of a structured objective assessment of the impact of substance use or dependence on the recipient's functioning in the following areas: drug use, alcohol use, legal system involvement, employment and/or school issues, and medical, family-social, and psychiatric issues. If indicated by history or structured assessment, a psychological examination and psychiatric examination shall be included as part of this evaluation. The assessment must be a written report as specified at 12VAC30-60-250 and must document the medical necessity for the service.~~

~~C. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.~~

12VAC30-50-491. ~~Case~~ Substance use case management services for individuals who have ~~an Axis I~~ a primary diagnosis of ~~substance-related~~ substance use disorder.

A. Target group: The Medicaid eligible ~~recipient~~ individual shall meet the Diagnostic and Statistical Manual of Mental Disorders ~~(DSM-IV-TR)~~ 5 diagnostic criteria for ~~an Axis I substance-related~~ a substance use disorder. ~~Nicotine~~ Tobacco-related disorders or caffeine ~~abuse or dependence~~ related disorders and non-substance-related disorders shall not be covered. ~~An active client for case~~ Substance use case management shall ~~mean a recipient for whom there is a plan of care in effect~~ include an active individual service plan (ISP) which requires ~~regular direct or recipient-related contacts or communication or activity with the recipient, family or service providers, including~~ a minimum of two substance use case management service activities each month, and at least one face-to-face contact with the ~~recipient~~ individual at least every 90 calendar days.

B. Services will be provided to the entire state.

C. Comparability of services: Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of services: Substance ~~abuse~~ use case management services ~~assist recipients~~ assist individuals and their family members in accessing needed medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the individual's basic needs. ~~The maximum service limit for case management services is 52 hours per year. Case management services are not reimbursable for recipients individuals residing in institutions, including institutions for mental disease.~~ Substance use case management is reimbursable on a monthly basis only when the minimum substance use case management service activities are met. Substance use case management services are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow

for discharge planning. This is limited to two one-month periods during a 12-month period. Tobacco-related disorders or caffeine-related disorders and non-substance-related disorders shall not be covered. Substance use case management does not include maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs. Substance use case management services are to be person-centered, individualized, culturally and linguistically appropriate to meet the individual's and family member's needs.

~~Services~~ Substance use case management service activities to be provided shall include:

~~1. Assessment and planning services, to include developing an Individual Service Plan (does not include performing assessments for severity of substance abuse or dependence, medical, psychological and psychiatric assessment, but does include referral for such assessment);~~

~~2. Linking the recipient to services and supports specified in the Individual Service Plan. When available, assessment and evaluation information should be integrated into the Individual Service Plan within two weeks of completion. The Individual Service Plan shall utilize accepted patient placement criteria and shall be fully completed within 30 days of initiation of service;~~

~~3. Assisting the recipient directly for the purpose of locating, developing, or obtaining needed services and resources;~~

~~4. Coordinating services and service planning with other agencies and providers involved with the recipient;~~

~~5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;~~

~~6. Making collateral contacts with the recipients' significant others to promote implementation of the service plan and community adjustment;~~

~~7. Follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and~~

~~8. Education regarding the need for services identified in the Individualized Service Plan (ISP).~~

~~Nicotine or caffeine abuse or dependence shall not be covered.~~

1. Assessing needs and planning services to include developing a substance use case management ISP. The ISP shall utilize accepted placement criteria and shall be fully completed within 30 calendar days of initiation of service.

2. Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;

3. Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's ISP and his community adjustment;

4. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative, recovery, and life goals of the individual as developed in the ISP;

5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;

6. Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.

7. Monitoring service delivery through contacts with individuals receiving services and service providers and site and home visits to assess the quality of care and satisfaction of the individual;

8. Providing follow-up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP;

9. Advocating for individuals in response to their changing needs, based on changes in the ISP;

10. Planning for transitions in the individual's life;

11. Knowing and monitoring the individual's health status, any medical conditions, medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed; and

12. Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other participants, or staff at risk of serious harm.

E. Qualifications of providers:

1. The provider of ~~substance abuse~~ substance use case management services must meet the following criteria:

a. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements;

b. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

c. The enrolled provider must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of substance abuse case management services.

2. Providers may bill Medicaid for substance ~~abuse~~ use case management only when the services are provided by a professional or professionals who meet at least one of the following criteria:

a. At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of substance ~~abuse~~ use related ~~clinical~~ direct experience providing ~~direct~~ services to ~~persons~~ individuals with a diagnosis of ~~mental illness or~~ substance ~~abuse~~ use disorder;

b. Licensure by the Commonwealth as a registered nurse ~~or as a practical nurse~~ with at least one year of ~~clinical~~ direct substance use treatment experience; or

c. ~~At least a bachelor's degree in any field and certification as a~~ A ~~substance abuse counselor~~ Board of Counseling Certified Substance Abuse Counselor (CSAC) or CSAC-Assistant under supervision as defined in 18VAC115-30-10 et seq. ~~or has at least a bachelor's degree in any field and is a certified addictions counselor (CAC)~~.

F. The state assures that the provision of substance use case management services will not restrict ~~a recipient's~~ an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible ~~recipients~~ individuals shall have free choice of the providers of substance use case management services.

2. Eligible ~~recipients~~ individuals shall have free choice of the providers of other services under the plan.

G. Payment for substance ~~abuse treatment~~ use case management or substance use care coordination services under the Plan does not duplicate payments for other case management made to public agencies or private entities under other Title XIX program authorities for this same purpose.

H. The state assures that the individual will not be compelled to receive substance use case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

I. The state assures that providers of substance use case management service do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

J. The state assures that substance use case management is only provided by and reimbursed to community case management providers.

K. The state assures that substance use case management does not include the following:

1. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

2. Activities for which an individual may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an individualized education program or individualized family service plan consistent with § 1903(c)of the Social Security Act.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION

Part V
Expanded Prenatal Care Services

12VAC30-50-510. Requirements and limits applicable to specific services: expanded prenatal care services.

A. Comparability of services: Services are not comparable in amount, duration and scope. Authority of § 9501(b) of COBRA 1985 allows an exception to provide service to pregnant women without regard to the requirements of § 1902(a)(10)(B).

B. Definition of services: Expanded prenatal care services will offer a more comprehensive prenatal care services package to improve pregnancy outcome. The expanded prenatal care services provider may perform the following services:

1. Patient education. Includes six classes of education for pregnant women in a planned, organized teaching environment including but not limited to topics such as body changes, danger signals, substance abuse, labor and delivery information, and courses such as planned parenthood, Lamaze, smoking cessation, and child rearing. Instruction must be rendered by Medicaid certified providers who have appropriate education, license, or certification.

2. Homemaker. Includes those services necessary to maintain household routine for pregnant women, primarily in third trimester, who need bed rest. Services include, but are not limited to, light housekeeping, child care, laundry, shopping, and meal preparation. Must be rendered by Medicaid certified providers.

3. Nutrition. Includes nutritional assessment of dietary habits, and nutritional counseling and counseling follow-up. All pregnant women are expected to receive basic nutrition information from their medical care providers or the WIC Program.

Must be provided by a Registered Dietitian (R.D.) or a person with a master's degree in nutrition, maternal and child health, or clinical dietetics with experience in public health, maternal and child nutrition, or clinical dietetics.

4. Blood glucose meters. Effective on and after July 1, 1993, blood glucose test products shall be provided when they are determined by the physician to be medically necessary for pregnant women suffering from a condition of diabetes which is likely to negatively affect their pregnancy outcomes. The women authorized to receive a blood glucose meter must also be referred for nutritional counseling. Such products shall be provided by Medicaid enrolled durable medical equipment providers.

5. ~~Residential substance abuse treatment services for pregnant and postpartum women. Includes comprehensive, intensive residential treatment for pregnant and postpartum women to improve pregnancy outcomes by eliminating the substance abuse problem. Must be provided consistent with standards established to assure high quality of care in 12VAC30-60. Residential substance abuse treatment services for pregnant and postpartum women shall provide intensive intervention services in residential facilities other than inpatient facilities and shall be provided to pregnant and postpartum women (up to 60 days postpartum) with serious substance abuse disorders, for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. The woman may keep her infant and other dependent children with her at the treatment center. The daily rate is inclusive of all services which are provided to the pregnant woman in the program. A unit of service shall be one day. The maximum number of units to be covered per pregnancy is 300 days, not to exceed 60 days postpartum. These services must be reauthorized every 90 days and after any absence of less than 72 hours which was not first authorized by the program director. The program director must document the reason for granting permission for any absences in the clinical record of the recipient. An unauthorized absence of more than 72 hours shall terminate Medicaid reimbursement for this service. Unauthorized hours absent from treatment shall be included in this lifetime service limit.~~

~~This type of treatment shall provide the following types of services or activities in order to be eligible to receive reimbursement by Medicaid:~~

~~a. Substance abuse rehabilitation, counseling and treatment must include, but is not necessarily limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes if needed; education about relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.~~

~~b. Training about pregnancy and fetal development shall be provided at a level and in a manner comprehensible by the participating women to include, but is not necessarily limited to, the impact of alcohol and other drugs on fetal development, normal physical changes associated with pregnancy as well as training in normal gynecological functions, personal nutrition, delivery expectations, and infant nutrition.~~

~~c. Initial and ongoing assessments shall be provided specifically for substance abuse, including, but not limited to, psychiatric and psychological assessments.~~

~~d. Symptom and behavior management as appropriate for co-existing mental illness shall be provided, including medication management and ongoing psychological treatment.~~

~~e. Personal health care training and assistance shall be provided. Such training shall include:~~

~~(1) Educational services and referral services for testing, counseling, and management of HIV, provided as described in 42 USC § 300x-24(b)(6)(A) and (B), including early intervention services as defined in 42 USC § 300x-24(b)(7) and in coordination with the programs identified in 45 CFR 96.128;~~

~~(2) Educational services and referral services for testing, counseling, and management of tuberculosis, including tuberculosis services as described in 42 USC § 300x-24(a)(2) (1992) and in coordination with the programs identified in 45 CFR 96.127; and~~

~~(3) Education services and referral services for testing, counseling, and management of hepatitis.~~

~~f. Case coordination with providers of primary medical care shall be provided, including obstetrical/gynecological services for the recipient.~~

~~g. Training in decision-making, anger management and conflict resolution shall be provided.~~

~~h. Extensive discharge planning shall be provided in collaboration with the recipient, any appropriate significant others, and representatives of appropriate service agencies.~~

~~6. Substance abuse day treatment for pregnant and postpartum women. Includes comprehensive, intensive day treatment for pregnant and postpartum women to improve pregnancy outcomes by eliminating the substance abuse problem. Must be provided consistent with the standards established to assure high quality of care in 12VAC30-60.~~

~~Substance abuse day treatment services for pregnant and postpartum women shall provide intensive intervention services at a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week, to pregnant and postpartum women (up to 60 days postpartum) with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, and achieving and maintaining a sober and drug-free lifestyle. The pregnant woman may keep her infant and other dependent children with her at the treatment center. One unit of service shall equal two but no more than 3.99 hours on a given day. Two units of service shall equal at least four but no more than 6.99 hours on a given day. Three units of service shall equal seven or more hours on a given day. The limit on this service shall be 400 units per pregnancy, not to exceed 60 days post partum. Services must be reauthorized every 90 days and after any absence of five consecutive days from scheduled treatment without staff permission. More than two episodes of five-day absences from scheduled treatment without prior permission from the program director or one absence exceeding seven days of scheduled treatment without prior permission from the program director shall terminate Medicaid funding for this service. The program director must document the reason for granting permission for any absences in the clinical record of the recipient. Unauthorized hours absent from treatment shall be included in the lifetime service limit. In order to be eligible to receive Medicaid payment the following types of services shall be provided:~~

~~a. Substance abuse rehabilitation, counseling and treatment shall be provided, including education about the impact of alcohol and other drugs on the fetus and on the maternal relationship, smoking cessation classes if needed; relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.~~

~~b. Training about pregnancy and fetal development shall be provided at a level and in a manner comprehensible by the participating women to include, but not necessarily be limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy, as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.~~

~~c. Initial and ongoing assessments shall be provided specifically for substance abuse, including psychiatric and psychological assessments.~~

~~d. Symptom and behavior management as appropriate for co-existing mental illness shall be provided, including medication management and ongoing psychological treatment.~~

~~e. Personal health care training and assistance shall be provided. Such training shall include:~~

~~(1) Educational services and referral services for testing, counseling, and management of HIV, provided as described in 42 USC § 300x-24(b)(6)(A) and (B), including early intervention services as defined in 42 USC § 300x-24(b)(7) and in coordination with the programs identified in 45 CFR 96.128;~~

~~(2) Educational services and referral services for testing, counseling, and management of tuberculosis, including tuberculosis services as described in 42 USC § 300x-24(a)(2) (1992) and in coordination with the programs identified in 45 CFR 96.127; and~~

~~(3) Educational services and referral services for testing, counseling, and management of hepatitis.~~

~~f. Case coordination with providers of primary medical care shall be provided, including obstetrics and gynecology services for the recipient.~~

~~g. Training in decision-making, anger management and conflict resolution shall be provided.~~

~~h. Extensive discharge planning shall be provided in collaboration with the recipient, any appropriate significant others, as well as representatives of appropriate service agencies.~~ Addiction and recovery treatment services shall be covered in expanded prenatal care services consistent with 12 VAC 30-130-5000 et seq.

C. Qualified providers.

~~1. Any duly enrolled provider which the department determines to be qualified who has signed an agreement may provide expanded prenatal care services.~~

~~2. The qualified providers will provide prenatal care services regardless of their capacity to provide any other services under the Plan.~~

~~3.~~ Providers of ~~substance abuse treatment services must be licensed and approved by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). Substance abuse services providers shall be required to meet the standards and criteria established by DMHMRSAS and the following additional requirements:~~ addiction and recovery treatment services shall meet the requirements of 12 VAC 30-130-5000 et seq.

~~a. The provider shall ensure that recipients have access to emergency services on a 24-hour basis seven days per week, 365 days per year, either directly or via an on-call system.~~

~~b. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the following professionals who must not be the same individual providing nonmedical clinical supervision:~~

~~(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Counselors, as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.~~

~~(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.~~

~~(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.~~

~~c. A provider of substance abuse treatment services for pregnant and postpartum women must meet the following requirements for day treatment services for pregnant and postpartum women:~~

~~(1) Medical care must be coordinated by a nurse case manager who is a registered nurse licensed by the Board of Nursing and who demonstrates competency in the following areas:~~

~~(a) Health assessment;~~

~~(b) Mental health;~~

~~(c) Substance abuse;~~

~~(d) Obstetrics and gynecology;~~

~~(e) Case management;~~

~~(f) Nutrition;~~

~~(g) Cultural differences; and~~

~~(h) Counseling.~~

~~(2) The nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.~~

12VAC30-60-147. ~~Substance abuse treatment services utilization review criteria.~~ (Repealed.)

~~A. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services that must be provided to participants, linkages to other programs tailored to specific individual needs, and program staff qualifications. The following services must be rendered to program~~

~~participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.~~

~~1. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC30-50-510.~~

~~a. To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.~~

~~b. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate reauthorizations after absences.~~

~~c. Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.~~

~~d. The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.~~

~~e. The ISP shall be reviewed and updated every two weeks.~~

~~f. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.~~

~~g. Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.~~

~~h. While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health, intellectual disability, or substance abuse rehabilitation services concurrently rendered to her.~~

~~i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.~~

~~2. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:~~

~~a. The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.~~

~~b. The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the woman and ongoing training and consultation to the staff of the program.~~

~~c. In addition, the provider must provide access to the following services either through staff at the residential program or through contract:~~

~~(1) Psychiatric assessments as needed, which must be performed by a physician licensed to practice by the Virginia Board of Medicine.~~

~~(2) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.~~

~~(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.~~

~~(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology.~~

~~(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., other Medicaid-sponsored primary health care programs).~~

~~3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:~~

~~a. The provider of treatment services shall be licensed by DBHDS to provide residential substance abuse services.~~

~~b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:~~

~~(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Counseling of the Virginia Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.~~

~~(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.~~

~~(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.~~

~~c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity~~

~~count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.~~

~~d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.~~

~~B. Substance abuse day treatment services for pregnant and postpartum women. This subsection provides for required services that must be provided to women, linkages to other programs tailored to specific needs, and program and staff qualifications.~~

~~1. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:~~

~~a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in 12VAC30-50-510.~~

~~b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II.1 (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II.1 (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.~~

~~c. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations, as well as the appropriate reauthorizations after absences.~~

~~d. Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.~~

~~e. The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30-day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.~~

~~f. The ISP shall be reviewed and updated every four weeks.~~

~~g. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.~~

~~h. Face-to-face therapeutic contact with the woman, which is directly related to her ISP, shall be documented at least once per week.~~

~~i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning shall seek to begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority~~

~~services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.~~

~~j. While participating in this substance abuse day treatment program, the only other mental health, intellectual disability, or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.~~

~~2. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation.~~

~~a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.~~

~~b. The program must have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the women and ongoing training and consultation to the staff of the program.~~

~~c. In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):~~

~~(1) Psychiatric assessments, which must be performed by a physician licensed to practice by the Board of Medicine of the Virginia Department of Health Professions.~~

~~(2) Psychological assessments, as needed, which must be performed by clinical psychologist licensed to practice by the Virginia Board of Psychology.~~

~~(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Virginia Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.~~

~~(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.~~

~~(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., other Medicaid-sponsored primary health care programs).~~

~~3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:~~

~~a. The provider of treatment services shall be licensed by DBHDS to provide either substance abuse outpatient services or substance abuse day treatment services.~~

~~b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following appropriately licensed professionals:~~

~~(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Virginia Board of Counseling or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.~~

~~(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning;~~

~~referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.~~

~~(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.~~

~~c. The minimum ratio of clinical staff to women should ensure that adequate staff are available to address the needs of the women in the program.~~

12VAC30-60-180. ~~Utilization review of community substance abuse treatment services.~~ (Repealed.)

~~A. To be eligible to receive these substance abuse treatment services, Medicaid recipients must meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria as prescribed in Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders (ASAM PPC-2R) shall be used to determine the appropriate level of treatment. Referrals for medical examinations shall be made consistent with the Early Periodic Screening and Diagnosis Screening Schedule.~~

~~B. Provider qualifications.~~

~~1. For Medicaid reimbursed Substance Abuse Day Treatment, Substance Abuse Intensive Outpatient Services, Opioid Treatment Services, a Qualified Substance Abuse Professional (QSAP) is defined as:~~

~~a. An individual who has completed master's level training in psychology, social work, counseling, or rehabilitation who also either:~~

~~(1) Is certified as a substance abuse counselor by the Virginia Board of Counseling;~~

~~(2) Is certified as an addictions counselor by the Substance Abuse Certification Alliance of Virginia; or~~

~~(3) Holds any certification from the National Association of Alcoholism and Drug Abuse Counselors, or the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC);~~

~~b. An individual licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, psychiatric clinical nurse specialist, psychiatric nurse practitioner, marriage and family therapist, clinical psychologist, or physician who is qualified by training and experience in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities;~~

~~c. An individual who is licensed as a substance abuse treatment practitioner by the Virginia Board of Counseling;~~

~~d. An individual who is certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC);~~

~~e. An individual who has completed master's level training in psychology, social work, counseling, or rehabilitation and is certified as a Master Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC) ;~~

~~f. An individual who has completed a bachelor's degree and is certified as a Substance Abuse Counselor by the Board of Counseling;~~

~~g. An individual who has completed a bachelor's degree and is certified as an Addictions Counselor by the Substance Abuse Certification Alliance of Virginia; or~~

~~h. An individual who has completed a bachelor's degree and is certified as a Level II Addiction Counselor by the National Association of Alcoholism and Drug Abuse Counselors or by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc (IC & RC).~~

~~If staff providing services meet only the criteria specified in subdivisions 1 f through h of this subsection, they must be supervised every two weeks by a professional who meets one of the criteria specified in subdivisions 1 a through e of this subsection. Supervision shall include documented face-to-face meetings between the supervisor and the professional providing the services. Documentation shall include review and approval of the plan of care for each recipient to whom services were provided but shall not require that the supervisor be onsite at the time the treatment service is provided.~~

~~2. In order to provide substance abuse treatment services, a paraprofessional (peer support specialist) must meet the following qualifications:~~

~~a. An associate's degree in one of the following related fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, or human services counseling) and has at least one year of experience providing direct services to persons with a diagnosis of mental illness or substance abuse;~~

~~b. An associate's or higher degree, in an unrelated field and at least three years experience providing direct services to persons with a diagnosis of mental illness, substance abuse, gerontology clients, or special education clients. The experience may include supervised internships, practicums, and field experience;~~

~~c. A minimum of 90 hours classroom training in behavioral health and 12 weeks of experience under the direct personal supervision of a QSAP providing services to persons with mental illness or substance abuse and at least one year of clinical experience (including the 12 weeks of supervised experience);~~

~~d. College credits (from an accredited college) earned toward a bachelor's degree in a human service field that is equivalent to an associate's degree and one year's clinical experience; and~~

~~e. Licensure by the Commonwealth as a practical nurse with at least one year of clinical experience.~~

~~3. Paraprofessionals must participate in clinical supervision with a QSAP at least twice a month. Supervision shall include documented face-to-face meetings between the supervisor and the professional providing the services. Supervision may occur individually or in a group.~~

~~4. All providers of substance abuse treatment services must adhere to the requirements of 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.~~

~~5. Day treatment providers must be licensed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) as providers of day treatment services. Intensive outpatient providers must be licensed by the DBHDS as providers of outpatient substance abuse services. The enrolled provider of opioid treatment services must be licensed as a provider of opioid treatment services by DBHDS.~~

~~C. Evaluations/assessments of the recipient shall be required for day treatment, intensive outpatient, and opioid treatment services. A structured interview shall be documented as a written report that provides recommendations substantiated by the findings of the evaluation and shall document the need for the specific service. Evaluations shall be reimbursed as part of day treatment, intensive outpatient, and opioid treatment services. The structured interview must be conducted by a qualified substance abuse professional as defined above.~~

~~D. Individual Service Plan (ISP) for day treatment, intensive outpatient, and opioid treatment services.~~

~~1. An initial ISP must be developed. A comprehensive ISP must be fully developed within 30 calendar days of admission to the service.~~

~~2. A comprehensive Individual Service Plan shall be developed with the recipient, in consultation with the individual's family, as appropriate, and must address: (i) a summary or reference to the evaluation; (ii) short-term and long-term goals and measurable objectives for addressing each identified individually specific need; (iii) services and supports and frequency of service to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; and (vi) the role of other agencies if the plan is a shared responsibility and the staff responsible for the coordination and the integration of services, including designated persons of other agencies if the plan is a shared responsibility. The ISP must be reviewed at least every 90 calendar days and must be modified as appropriate.~~

~~E. Individuals shall not receive any combination of day treatment, opioid treatment, and intensive outpatient services concurrently.~~

~~F. Crisis intervention. Admission to crisis intervention services is indicated following a marked reduction in the recipient's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress that is related to the use of alcohol or other drugs. Crisis intervention may be the initial contact with a recipient.~~

~~1. The provider of crisis intervention services shall be licensed as a provider of Substance Abuse Outpatient Services by DBHDS. Providers may bill Medicaid for substance abuse crisis intervention only when the services are provided by either a professional or professionals who meet at least one of the criteria listed herein.~~

~~2. Only recipient-related activities provided in association with a face-to-face contact shall be reimbursable.~~

~~3. An ISP shall not be required for newly admitted recipients to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.~~

~~4. Other than the annual service limits, there shall be no restrictions (regarding numbers of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts. An ISP must be developed within 30 days of service initiation.~~

~~5. For recipients receiving scheduled, short-term counseling as part of the crisis intervention service, the ISP must reflect the short-term counseling goals.~~

~~6. Crisis intervention services may be provided outside of the clinic and billed, provided the provision of out-of-clinic services is clinically or programmatically appropriate for the recipient's needs, and it is included on the ISP. Travel by staff to provide out-of-clinic services shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others.~~

~~7. Documentation must include the efforts at resolving the crisis to prevent institutional admissions.~~

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-181. Utilization review of addiction, recovery and treatment services (ARTS) .

A. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the providers' care. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered. Claims that are not adequately supported by appropriate up to date documentation may be subject to recovery of expenditures.

B. Utilization reviews shall be conducted by DMAS or its designated contractor.

C. Service authorizations shall be required for ASAM levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0.

D. A multidimensional assessment by a credentialed addiction treatment professional, as defined in 12VAC30-130-5020, shall be required for ASAM levels of care 1.0 through 4.0. The multidimensional assessment shall be maintained in the individual's record by the provider. Medical necessity for all ASAM levels of care shall be based on the outcome of the individual's multidimensional assessment.

E. Individual service plans (ISPs) and treatment plans shall be developed upon admission to medically managed intensive inpatient services (ASAM 4), substance use residential/inpatient services (ASAM levels 3.1, 3.3, 3.5, and 3,7), and substance use intensive outpatient and partial hospitalization programs (ASAM levels 2.1 and 2.5). ISPs or treatment plans shall be developed upon initiation of Opioid Treatment Services (OTP) and Office Based Opioid Treatment (OBOT); substance use outpatient services (ASAM level 1).

1. The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP or treatment plan. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated at least annually and as the individual's needs and progress change. An ISP that is not updated either annually or as the individual's needs and progress change shall be considered outdated.

2. All ISPs shall be completed and contemporaneously signed and dated by the credentialed addiction treatment professional preparing the ISP.

3. The child's or adolescent's ISP shall also be signed by the parent/legal guardian and the adult individual shall sign his own ISP. If the individual, whether a child, adolescent, or adult is unwilling or unable to sign the ISP, then the service provider shall document the reasons why the individual was not able or willing to sign the ISP.

F. A comprehensive ISP, as defined in 12VAC30-130-5020, shall be fully developed within 30 calendar days of the initiation of services. The

comprehensive ISP shall be developed with the individual, in consultation with the individual's family, as appropriate, and shall address: (i) a summary or reference to the individual's identified needs; (ii) short-term and long-term goals and measurable objectives for addressing each identified individually-specific need; (iii) services and supports and frequency of services to accomplish the goals and objectives; (iv) target dates for accomplishment of goals and objectives; (v) estimated duration of service; and (vi) the role or roles of other agencies if the plan is a shared responsibility and the staff designated as responsible for the coordination and the integration of services. The ISP shall be reviewed at least every 90 calendar days and shall be modified as the needs and progress of the individual changes. Documentation of the ISP review shall include the dated signatures of the credentialed addiction treatment professional and the individual.

G. Progress notes, as defined in 12 VAC 30-130-5020, shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes may be subject to recovery of expenditures.

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Statutory Authority

THE TEXT OF THESE REGULATIONS IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-185. Utilization review of substance use case management.

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-130-5020.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes and are part of the minimum documentation requirements that convey the individual's status, staff intervention, and as appropriate, the individual's progress or lack of progress toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed for each rendered service. Progress notes shall be documented for each service that is billed.

"Register" or "registration" means notifying DMAS or its contractor that an idividual will be receiving services that do not require service authorization such as outpatient services for substance use disorders or substance use case management.

~~A.~~ B. Utilization review: ~~community substance abuse treatment~~ substance use case management services.

1. The Medicaid ~~recipient~~ enrolled individual shall meet the Diagnostic and Statistical Manual of Mental Disorders ~~(DSM-IV-TR)~~ (DSM-V) criteria for ~~an Axis I substance-related~~ substance use disorder. ~~Nicotine~~ Tobacco-related disorders or caffeine abuse ~~or dependence~~ and non-substance-related disorders shall not be covered.

2. Reimbursement shall be provided only for "active" case management. An active client for substance use case management shall mean an individual for whom there is a ~~plan of care~~ current substance use Individual Service Plan (ISP) in effect that requires ~~regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including~~ a minimum of two distinct substance use case management activities being performed each calendar month and at a minimum one face-to-face client contact ~~within a 90-day~~ at least every 90 calendar day period.

~~3. Except for a 30-day period following the initiation of this case management service by the recipient, in order to continue receiving case management services, the Medicaid recipient must be receiving another substance abuse treatment service.~~

~~4.~~ 3. Billing can be submitted for an active recipient only for months in which ~~direct or client-related contacts, activity, or communications occur~~ a minimum of two distinct substance use case management activities are performed.

~~5. There is a maximum annual service limit of 52 hours for case management services.~~

~~6.~~ 4. ~~An initial Individual Service Plan (ISP)~~ An ISP ~~must~~ shall be completed within 30 calendar days of initiation of this service with the individual in a person-centered manner and ~~must~~ shall document the need for active substance use case management before such case management services can be billed. ~~A~~ The ~~comprehensive~~ ISP ~~shall be fully developed within 30 days of initiation of this service, which requires regular direct or recipient-related contacts or activity or communication with the recipient or families, significant others, service providers, and others including~~ shall require a minimum of two distinct substance use case management activities being performed each calendar month and a minimum of one face-to-face client contact at least every 90 calendar days. The substance use case manager shall review the ISP with the individual at least every 90 calendar days for the purpose of evaluating and updating ~~it or otherwise modifying it as appropriate for the recipient's changing condition~~ the individual's progress toward meeting the individualized service plan objectives.

~~7. The ISP shall be updated at least every 90 days or within seven days of a change in the recipient's treatment.~~

5. The ISP shall be reviewed with the individual present, and the outcome of the review documented in the individual's medical record.

~~B.~~C. Utilization review: substance ~~abuse treatment~~ use case management services.

1. Utilization review general requirements. ~~On-site utilization reviews shall be conducted.~~ Utilization reviews shall be conducted by DMAS or its designated contractor. Reimbursement shall be provided only ~~for "active" case management clients. An active client for case management shall mean an individual for whom there is a plan of care in effect that requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including~~ when there is an active ISP and a minimum of two distinct substance use case management activities are performed each calendar month and there is a minimum of one face-to-face client contact ~~within a 90-day~~ at least every 90 calendar day period. Billing can be submitted only for months in which ~~direct or client-related contacts, activity or communications occur~~ a minimum of two distinct substance use case management activities are performed within the calendar month.

2. ~~The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR) criteria for an Axis I Substance Abuse Disorder~~ a

~~with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for reimbursement of these services.~~ In order to receive reimbursement, providers shall register this service with the MCO or the BHSA, as required, within one business day of service initiation to avoid duplication of services and to ensure informed and seamless care coordination between substance use treatment and substance use case management providers.

3. The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria for a substance use disorder with the exception of tobacco-related or caffeine-related and non-substance-related disorders.

~~3. The maximum annual limit for substance abuse treatment case management shall be 52 hours per year.~~

4. ~~Case~~ Substance use case management shall not be billed for ~~persons~~ individuals in institutions for mental disease, except during the month prior to discharge to allow for discharge planning, limited to two months within a 12-month period. Substance ~~abuse treatment~~ use case management shall not be billed concurrently with any other type of Medicaid reimbursed case management and care coordination.

~~4.~~5. The ISP, as defined in 12 VAC 30-130-5020, ~~must~~ shall document the need for substance use case management and be fully completed within 30 calendar days of initiation of the service and the substance use case manager shall review the ISP at least every ~~three months~~ 90 calendar days. Such reviews ~~must~~ shall be documented in the ~~client's~~ individual's medical record. ~~The review will be due by the last day of the third month following the month in which the last review was completed.~~ If needed a grace period will be granted ~~up to the last day of the fourth month~~ following the ~~month~~ date of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled ~~three months~~ 90 calendar days from the ~~month~~ date the review was initially due and not the date of actual review.

~~5.~~6. The ISP shall be updated and documented in the individual's medical record at least annually and as an individual's needs change.

~~6.~~7. The provider of substance use case management services shall be licensed by DBHDS as a provider of substance use case management, and credentialed by the BHSA or MCO as a provider of substance use case management services.

8. Progress notes, as herein defined, shall be required to disclose the extent of services provided and corroborate the units billed.

Part V
Inpatient Hospital Payment System

Article 1
Application of Payment Methodologies

12VAC30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services, as set out in 12 VAC 30-50-100, in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs. Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection F of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

E. Reduction of payments methodology.

1. For state fiscal years 2003 and 2004, the Department of Medical Assistance Services (DMAS) shall reduce payments to hospitals participating in the Virginia Medicaid Program by $8,935,825 total funds, and $9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the total reduction amount shall be determined as provided in this subsection.

2. Determine base for revenue forecast.

a. DMAS shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and outpatient reimbursed cost, as recorded by DMAS for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated statewide HMO average percentage of Medicaid business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.

b. For freestanding psychiatric hospitals, DMAS shall use estimated Medicaid revenues for the six-month period (January 1, 2001, through June 30, 2001), times two, and adjusted for inflation by 4.3% for state fiscal year 2002, 3.1% for state fiscal year 2003, and 3.7% for state fiscal year 2004, as reported by DRI-WEFA, Inc.'s, hospital input price level percentage moving average.

3. Determine forecast revenue.

a. Each Type I hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 a of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type I hospitals.

b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type II hospitals.

4. Each hospital's total yearly reduction amount is equal to their respective state fiscal year 2003 and 2004 forecast reimbursement as described in subdivision 3 of this subsection, times 3.235857% for state fiscal year 2003, and 3.235857%, for the first two quarters of state fiscal year 2004 and 2.88572% for the last two quarters of state fiscal year 2004, not to be reduced by more than $500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in subdivision 4 of this subsection. Payment reduction offsets not covered by claims remittance by May 15, 2003, and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30, 2003, or 2004, as applicable.

F. Consistent with 42 CFR 447.26 and effective July 1, 2012, the Commonwealth shall not reimburse inpatient hospitals for provider-preventable conditions (PPCs), which include:

1. Health care-acquired conditions (HCACs). HCACs are conditions occurring in any hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

2. Other provider preventable conditions (OPPCs) as follows: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; or (iii) surgical or other invasive procedure performed on the wrong patient.

Article 2
Prospective (DRG-Based) Payment Methodology

12VAC30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a

hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. For Type Two hospitals, payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report. Effective April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"AP-DRG" means all patient diagnosis related groups.

"APR-DRG" means all patient refined diagnosis related groups.

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" means the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" means the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subdivision 2 of this definition does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG" means diagnosis related groups.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days (from DMAS MR reports for fee-for-service days and managed care organization or hospital reports for HMO days) and nonpaid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric distinct part unit (DPU), divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and includes (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD, as defined in 12VAC30-95-5. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" means when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as new cases. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Type One hospitals" means those hospitals that were state-owned teaching hospitals on January 1, 1996.

"Type Two hospitals" means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper. Effective October 1, 2014, "ungroupable cases" means cases assigned to DRG 955 (ungroupable) and DRG 956 (ungroupable) as determined by the APR-DRG grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) grouper shall be used in the DRG payment system. Effective October 1, 2014, DMAS shall replace the AP-DRG grouper with the All Patient Refined Diagnosis Related Groups (APR-DRG) grouper for hospital inpatient reimbursement. The APR-DRG Grouper will produce a DRG as well as a severity level ranging from 1 to 4. DMAS shall phase in the APR-DRG weights by blending in 50% of the full APR-DRG weights with 50% of fiscal year (FY) 2014 AP-DRG weights for each APR-DRG group and severity level in the first year. In the second year, the blend will be 75% of full APR-DRG weights and 25% of the FY 2014 AP-DRG weights. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and severity. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology	
Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file

Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims history file
Outlier adjustment factor	Federal Register

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT covered under 12 VAC 30-50-130(B)(6) and 12 VAC 30-130-5202.

A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of **12VAC30-70-321** plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in **12VAC30-70-271.**

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio total of capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of **12VAC30-50-130**, shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in **12VAC30-80** or elsewhere in the State Plan, to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in subdivision C 4 of **12VAC30-60-25**; and

2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT covered under 12VAC30-50-130(B)(6) and 12VAC30-130-5201 and 12VAC30-130-5220.

A. Effective January 1, 2000, DMAS shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by DMAS based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all services provided under arrangement that are reimbursed in the manner described in subsection D of this section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by DMAS at such time as required by DMAS. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, DMAS shall take action in accordance with its policies to assure that an overpayment is not being made.

D. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of **12VAC30-50-130**, shall be reimbursed directly by DMAS to a provider of services provided under arrangement according to the reimbursement methodology prescribed for that provider type elsewhere in the State Plan if all of the following are met:

1. The services provided under arrangement are included in the active written treatment plan of care developed and signed as described in section **12VAC30-130-890**; and

2. The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for services provided under arrangement.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION

12VAC30-80-32. Reimbursement for substance abuse services.

1. ~~Outpatient psychotherapy services for assessment and evaluation or treatment of substance abuse furnished by physicians shall be reimbursed using the methodology in 12VAC30-80-190. For nonphysicians, they shall be reimbursed at the same levels specified in 12VAC30-50-140 and 12VAC30-50-150.~~ Physician services described in 12VAC30-50-140, other licensed practitioner services described in 12VAC30-50-150 and clinic services described in 12VAC30-50-180 for assessment and evaluation or treatment of substance use disorders shall be reimbursed using the methodology in 12VAC30-80-30 and 12VAC30-80-190 subject to the following reductions for psychotherapy services for other licensed practitioners.

a. Psychotherapy services of a licensed clinical psychologist shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Psychotherapy services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed psychiatric nurse practitioners, licensed substance abuse treatment practitioner, or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

c. The same rates shall be paid to governmental and private providers. These services are reimbursed based on the Common Procedural Terminology (CPT) Codes and Healthcare Common Procedure Coding System (HCPCS) codes. The agency's rates were set as of July 1, 2007, and are updated as described in 12 VAC30-80-190. All rates are published on the DMAS website at: **www.dmas.virginia.gov**.

2. Rates for ~~other substance abuse~~ the following ARTS physician and clinic services shall be based on the agency fee schedule; ~~for 15-minute units of service;~~ Medication Assisted Treatment induction with a visit unit of service; individual and group opioid treatment service with a 15-minute unit of service; and substance use care coordination with a monthly unit of service. The agency's rates shall be set as of April 1, 2017. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. ~~For each level of professional necessary to provide services described in 12VAC30-50-228 and 12VAC30-50-491 separate rates shall be established for licensed professionals, qualified substance abuse professionals (QSAP) and paraprofessionals.~~ The same rates shall be paid to public and private providers. All rates are published on the DMAS website at: **www.dmas.virginia.gov**.

3. Community ~~substance abuse services: Rehabilitation~~ ARTS rehabilitation services. ~~Rates~~ Per diem rates for ~~community substance abuse rehabilitation services shall be based on the agency fee schedule for defined 15-minute units of service. Separate rates shall be established for licensed professionals, qualified substance abuse professionals (QSAP) and paraprofessionals as described in 12VAC30-50-228.~~ clinically managed low intensity residential services (ASAM 3.1), partial hospitalization (ASAM 2.5), and intensive outpatient (ASAM 2.1) for ARTS shall be based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates ~~were set as of July 1, 2007~~ shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at: **www.dmas.virginia.gov**.

~~4. Outpatient substance abuse services: Physician services. Outpatient psychotherapy services for assessment and evaluation or treatment of substance abuse furnished by physicians, as described in 12VAC30-50-140, shall be reimbursed using the methodology described in this section and in 12VAC30-80-190. The same rates shall be paid to governmental and private providers. These services are reimbursed based on the Common Procedural Terminology (CPT) Codes. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the DMAS website at: **www.dmas.virginia.gov**.~~ ARTS FQHC/RHC Services. FQHC/RHC services (ASAM 1.0) for assessment and evaluation or treatment of substance use disorder, as described in 12 VAC 30-130-5000 et seq., shall be reimbursed using the methodology described in 12 VAC 30-80-25.

~~5. Outpatient substance abuse services: Other providers, including Licensed Mental Health Professionals (LMHP). Outpatient substance abuse services~~

~~furnished by other licensed practitioners, as described in 12VAC30-50-150, shall be reimbursed using the methodology described in section 12VAC30-80-30 and in 12VAC30-80-190 and based upon the percentages set forth below. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the DMAS website website at: www.dmas.virginia.gov.~~

~~a. Services of a licensed clinical psychologist shall be reimbursed at 90% of the reimbursement rate for psychiatrists.~~

~~b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, psychiatric nurse practitioners, licensed substance abuse treatment practitioner, or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.~~

~~6. Substance abuse services: Clinic services. Outpatient psychotherapy services for assessment and evaluation or treatment of substance abuse furnished by clinics as described in 12VAC30-50-150, shall be reimbursed using the methodology described in 12VAC30-80-30 and in 12VAC30-80-190. The fee schedule in effect, as of July 1, 2007, is an aggregate that is approximately 80% of the Medicare rates for these services. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the DMAS website at: www.dmas.virginia.gov.~~

~~7. Substance abuse services: Case management services. Substance abuse case management services furnished by professionals as described in 12VAC30-50-140, 12VAC30-50-150 and in 12VAC30-50-491, shall be reimbursed based on the agency fee schedule for 15 minute units of service. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2007, and are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov.~~

5. Substance use case management services. Substance use case management services as described in 12 VAC 30-50-491, shall be reimbursed a monthly rate based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payment shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at **www.dmas.virginia.gov**

Part VIII
Community Mental Health and Mental Retardation Services

12VAC30-130-540. ~~Definitions.~~ (Repealed.)

~~The following words and terms, when used in this part, shall have the following meanings unless the context clearly indicates otherwise:~~

~~"Board" or "BMAS" means the Board of Medical Assistance Services.~~

~~"CMS" means the Centers for Medicare and Medicaid Services as that unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.~~

~~"Code" means the Code of Virginia.~~

~~"Consumer service plan" means that document addressing the needs of the recipient of mental retardation case management services, in all life areas. Factors to be considered when this plan is developed are, but not limited to, the recipient's age, primary disability, level of functioning and other relevant factors.~~

~~"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.~~

~~"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.~~

~~"DRS" means the Department of Rehabilitative Services consistent with Chapter 3 (§ 51.5-8 et seq.) of Title 51.5 of the Code of Virginia.~~

~~"Individual Service Plan" or "ISP" means a comprehensive and regularly updated statement specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, and estimated timetable for achieving the goals and objectives. Such ISP shall be maintained up to date as the needs and progress of the individual changes.~~

~~"Medical or clinical necessity" means an item or service that must be consistent with the diagnosis or treatment of the individual's condition. It must be in accordance with the community standards of medical or clinical practice.~~

~~"Mental retardation" means the presence of a level of retardation (mild, moderate, severe, or profound) described in the American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983) or a related condition. A person with related conditions (RC) means the individual has a severe chronic disability that meets all of the following conditions:~~

~~1. It is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons;~~

~~2. It is manifested before the person reaches age 22;~~

~~3. It is likely to continue indefinitely; and~~

~~4. It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.~~

~~"Preauthorization" means the approval by the DMHMRSAS staff of the plan of care which specifies recipient and provider. Preauthorization is required before reimbursement can be made.~~

~~"Qualified case managers for mental health case management services" means individuals possessing a combination of mental health work experience or relevant education which indicates that the individual possesses the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.~~

~~"Qualified case managers for mental retardation case management services" means individuals possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses~~

~~the knowledge, skills, and abilities, as established by DMHMRSAS, necessary to perform case management services.~~

~~"Related conditions," as defined for persons residing in nursing facilities who have been determined through Annual Resident Review to require specialized services, means a severe, chronic disability that (i) is attributable to a mental or physical impairment (attributable to mental retardation, cerebral palsy, epilepsy, autism, or neurological impairment or related conditions) or combination of mental and physical impairments; (ii) is manifested before that person attains the age of 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major areas: self-care, language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and (v) results in the person's need for special care, treatment or services that are individually planned and coordinated and that are of lifelong or extended duration.~~

~~"Serious emotional disturbance" means that mental health problem as defined by the Board of Mental Health, Mental Retardation, and Substance Abuse Services in Policy 1029, Definitions of Priority Mental Health Populations, effective June 27, 1990.~~

~~"Serious mental illness" means that mental health problem as defined by the Board of Mental Health, Mental Retardation, and Substance Abuse Services in Policy 1029, Definitions of Priority Mental Health Populations, effective June 27, 1990.~~

~~"Significant others" means persons related to or interested in the individual's health, well-being, and care. Significant others may be, but are not limited to, a spouse, friend, relative, guardian, priest, minister, rabbi, physician, neighbor.~~

~~"Substance abuse" means the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior.~~

~~"State Plan for Medical Assistance" or "Plan" means the document listing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.~~

12VAC30-130-565. ~~Substance abuse treatment services.~~ (Repealed.)

~~A. Substance abuse treatment services shall be provided consistent with the criteria and requirements of 12VAC30-50-510.~~

~~B. The following criteria must be met and documented in the woman's record before Medicaid reimbursement for substance abuse residential treatment services for pregnant and postpartum women can occur:~~

~~1. The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the plan of care; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.~~

~~2. The woman must be pregnant at admission and intend to complete the pregnancy.~~

~~3. The woman must:~~

~~a. Have used alcohol or other drugs within six weeks of referral to the program. If the woman was in jail or prison prior to her referral to this program, the alcohol or drug use must have been within six weeks prior to jail or prison;~~

~~b. Be participating in less intensive treatment for substance abuse and be assessed as high-risk for relapse without more intensive intervention and treatment; or~~

~~c. Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.~~

~~4. The woman must be under the active care of a physician who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital which is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.~~

~~C. The following criteria must be met and documented in the woman's record before Medicaid reimbursement for substance abuse day treatment services for pregnant and postpartum women can occur:~~

~~1. The woman must agree to participate in developing her own treatment plan, to comply with the treatment plan, to utilize appropriate measures to negotiate changes in her treatment plan, to fully participate in treatment, to comply with program rules and procedures, and to complete the treatment plan in full.~~

~~2. The woman must be pregnant at admission and intend to complete the pregnancy.~~

~~3. The woman must:~~

~~a. Have used alcohol or other drugs within six weeks of referral to the program. If the woman was in jail or prison prior to her referral to this program, the alcohol or drug use must have been within six weeks prior to jail or prison;~~

~~b. Be participating in less intensive treatment for substance abuse and assessed as high-risk for relapse without more intensive intervention and treatment; or~~

~~c. Within 30 days of admission, have been discharged from a more intensive level of treatment for substance abuse, such as hospital-based or jail- or prison-based inpatient treatment or residential treatment.~~

~~4. The woman must be under the active care of a physician who is an approved Virginia Medicaid provider and who has obstetrical privileges at a hospital which is an approved Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician and the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.~~

12VAC30-130-580. ~~Free choice of providers.~~ (Repealed.)

~~The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.~~

~~1. Eligible recipients will have free choice of the providers of case management services.~~

~~2. Eligible recipients will have free choice of the providers of other medical care under the plan.~~

12VAC30-130-590. ~~Nonduplication of payment.~~ (Repealed.)

~~Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.~~

PART XX.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION

12VAC30-130-5000. Addiction and Recovery Treatment Services (ARTS).

The services provided for in this Part shall be known as either Addiction and Recovery Treatment Services (ARTS) or substance use disorder services.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-5005. ARTS Purpose.

The purpose of this Part shall be to establish coverage of treatment for substance use disorders as defined in the American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related and Co-occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine including outpatient physician and clinic services, residential treatment services and inpatient withdrawal management services as defined in 12VAC30-130-5100 through 12VAC30-130-5220.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-5020. Definitions.

The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Abstinence" as defined by the American Society of Addiction Medicine (ASAM), means the intentional and consistent restraint from the pathological pursuit of reward or relief, or both, that involves the use of substances.

"Addiction" means, as defined by the ASAM, a primary, chronic disease of brain reward, motivation, memory and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with ones behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Addiction credentialed physician" as defined by ASAM means a physician who holds a board certification in addiction medicine from the American Board of Addiction Medicine, a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology, or subspecialty board certification in addiction medicine from the American Osteopathic Association. In

situations where a certified addiction physician is not available, physicians treating addiction should have some specialty training or experience in addiction medicine or addiction psychiatry. If treating adolescents, they should have experience with adolescent medicine.

"Adherence" means, as defined by ASAM, the individual receiving treatment has demonstrated his ability to cooperate with, follow, and take personal responsibility for the implementation of his treatment plans.

"Adolescent" means an individual from 12 to 20 years of age.

"Allied Health Professional" means, as defined by ASAM, counselor aides or group living workers who meet the DBHDS licensing requirements.

"ARTS Care Coordinator" means a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, nurse practitioner or registered nurse with clinical experience in substance use disorders, who is employed by the BHSA or MCO to perform an independent assessment of requests for all ARTS residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0).

"ASAM Criteria dimensions" means the six different life areas used by the ASAM Patient Placement Criteria to develop a holistic biopsychosocial assessment of an individual that is used for service planning, level of care, and length of stay treatment decisions.

"Assertive Community Treatment (ACT)," or "Intensive Community Treatment" means, the same as defined in 12VAC30-50-226.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS. DMAS' designated BHSA shall be authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. DMAS shall retain authority for and oversight of the BHSA entity or entities.

"Buprenorphine Waivered Practitioners" means health care providers licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe schedule III, IV, or V medications for treatment of pain. Physicians shall have completed the buprenorphine waiver training course and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (DATA 2000). They shall have been issued a DEA-X number by the DEA to prescribe buprenorphine for the treatment of opioid use disorder. Practitioners who are not physicians must meet all federal and state requirements and be supervised by or work in collaboration with a qualifying physician who is buprenorphine waivered.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care to improve the care.

"Certified substance use counselor (CSAC)" or "certified substance abuse counselor-assistant (CSAC-A)" means an individual with certification through the Board of Counseling as a certified substance use counselor or as a certified substance use counselor-assistant who is under the supervision of a licensed provider and acting within the scope of the practice of his license.

"Child" means an individual from birth up to 12 years of age.

"Clinical experience" means, for the purpose of these ARTS requirements, practical experience in providing direct services to individuals with diagnoses of substance use disorder. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience.

"Code" means the Code of Virginia.

"Collateral services" means services provided by therapists or counselors for the purpose of engaging persons who are significant to the individual receiving SUD services. The services are focused on the individuals treatment needs and support achievement of his recovery goals.

"Co-occurring disorders" means, as defined by ASAM, the presence of concurrent substance use disorder and mental illness without implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other. Other terms used to describe co-occurring disorders include dual diagnosis, dual disorders, mentally ill chemically addicted (MICA), chemically addicted mentally ill (CAMI), mentally ill substance abusers (MISA), mentally ill chemically dependent (MICD), concurrent disorders, coexisting disorders, comorbid disorders, and individuals with co-occurring psychiatric and substance symptomatology (ICOPSS).

"Credentialed addiction treatment professionals " means an addiction-credentialed physician or physician with experience in addiction medicine; licensed psychiatrist; licensed clinical psychologist; licensed clinical social worker; licensed professional counselor; licensed psychiatric clinical nurse specialist; licensed psychiatric nurse practitioner; licensed marriage and family therapist; licensed substance abuse treatment practitioner; or "Residents" under supervision of licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10); and an individual with certification as a substance abuse counselor (CSAC) (18VAC115-30-10) or certified substance abuse counselor-assistant (CSAC-A) (18VAC115-30-10) under supervision of licensed provider and within scope of practice.(§ 54.1-3507.1 & § 54.1-3507.2).

"CSB/BHA" means Community Services Board or Behavioral Health Authority.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"DHP" means the Department of Health Professions.

"DMAS" or "the department" means the Department of Medical Assistance Services and its contractor or contractors consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Evidence-based practice" means an empirically-supported clinical practice or intervention with a proven ability to produce positive outcomes.

"FAMIS" means the Family Access to Medical Insurance Security as set out in 12 VAC 30-141 et seq.

"FQHC" means Federally Qualified Health Center.

"Individual" means the patient, client, beneficiary or member who receives services set out in 12 VAC 30-130-5000 et seq. These terms are used interchangeably.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-130-5020.

"Maintenance treatment or treatments," means pharmacotherapy on a consistent schedule for individuals with addiction, usually with an agonist or partial agonist, which mitigates against the pathological pursuit of reward or relief, or both, and allows remission of overt addiction-related problems. Maintenance treatments of addiction are associated with the development of a pharmacological steady state in which receptors for addictive substances are occupied, resulting in relative or complete blockade of central nervous system receptors such that addictive substances are no longer sought for reward or relief. Maintenance treatments of addiction are also designed to lessen the risk of overdose. Depending on the circumstances of a given case, an ISP including maintenance treatments can be time-limited or can remain in place for life. Integration of pharmacotherapy via maintenance treatments with psychosocial treatment generally is associated with the best clinical results. Maintenance treatments can be part of an individuals treatment plan in abstinence-based recovery activities or can be a part of harm reduction strategies.

"Managed Care Organization" or "MCO" means an organization which offers managed care health insurance plans (MCHIP), as defined by *Code of Virginia* § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

"Multidimensional assessment" means the individualized, person-centered biopsychosocial assessment performed face-to-face, in which the provider obtains comprehensive information from the individual (including family members and significant others as needed) including: history of the present illness; family history; developmental history; alcohol, tobacco, and other drug use or addictive behavior history; personal/social history; legal history; psychiatric history; medical history; spiritual history as appropriate; review of systems; mental status exam; physical examination; formulation and diagnoses; survey of assets, vulnerabilities and supports; and treatment recommendations. The ASAM Multidimensional Assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions: i) acute intoxication or withdrawal potential, or both, ii) biomedical conditions and complications, iii) emotional, behavioral, or cognitive conditions and complications, iv) readiness to change, v) relapse, continued use, or continued problem potential and vi) recovery/living environment. The level of care determination, ISP and recovery strategies development may be based upon this multidimensional assessment.

"Office-based opioid treatment" or "OBOT" means addiction treatment services for individuals with moderate to severe opioid use disorder provided by buprenorphine-waivered practitioners working in collaboration with credentialed

addiction treatment practitioners providing psychosocial counseling in public and private practice settings.

"Opiate" means, as defined by ASAM, one of a group of alkaloids derived from the opium poppy (*Papaver somniferum*) which has the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression but excludes synthetic opioids.

"Opioid" means any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and synthetic/semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their actions.

"Opioid treatment program (OTP)" means a program certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) that engages in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of individuals who are addicted to opioids.

"Opioid treatment services (OTS)" means, as defined by ASAM, office based opioid treatment (OBOT) and Opioid Treatment Programs (OTP) which encompass a variety of pharmacological and non-pharmacological treatment modalities.

"Overdose" means, as defined by ASAM, the inadvertent or deliberate consumption of a dose of a chemical substance much larger than either habitually used by the individual or ordinarily used for treatment of an illness which is likely to result in a serious toxic reaction or death.

"Physician extenders" means licensed nurse practitioners (18VAC90-30-10) and licensed physician assistants (18VAC85-50-10).

"Practitioner" means providers who are permitted to prescribe buprenorphine by the scope of their licenses under federal and state law.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have a substance use disorder or mental illness and their family members or caregivers to access clear and concise information about substance use disorders or mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about substance use disorders or mental illness, recovery, communicating and facilitating problem solving and increasing coping skills.

"Psychosocial treatment" means any non-pharmacological intervention carried out in a therapeutic context within a Medication Assisted Treatment program, at an individual, family, or group level which may include structured, professionally administered interventions (e.g., cognitive behavior therapy or insight-oriented psychotherapy) or nonprofessional interventions (e.g., self-help groups).

"Recovery" means, as defined by ASAM, a process of sustained effort that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction and consistently pursues abstinence, behavior control, dealing with cravings, recognizing problems in ones behaviors and interpersonal relationships, and more effective coping with emotional responses leading to reversal of negative, self-defeating internal processes and behaviors and allowing healing of

relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process.

"Registered nurse" or "RN" means a professional who is either licensed by the Commonwealth or who holds a multi-state licensure privilege to practice nursing.

"Relapse" means, as defined by ASAM, a process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward or relief through the use of substances and other behaviors often leading to disengagement from recovery activities. Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.

"Residents" means professionals under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), licensed substance abuse treatment practitioner (18VAC115-160-10) approved by the Virginia Board of Counseling, or residents in psychology under supervision of a licensed clinical psychologist (18VAC125-20-10) approved by the Virginia Board of Psychology.

"RHC" means rural health clinic.

"SBIRT" means screening, brief intervention, and referral to treatment.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor, BHSA, or MCO prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Substance use care coordinator" means an individual in an OTP or OBOT setting who has 1) at least a bachelor's degree in one of the following fields: social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling, and has at least one year of direct experience providing direct services to persons with a diagnosis of mental illness or substance use disorder; 2) licensure by the Commonwealth as a registered nurse with at least one year of direct experience; or 3) an individual with certification as a substance abuse counselor (CSAC).

"Substance use case management" means the same as set out in 12VAC30-50-491.

"Substance use case manager" means an entity that is licensed as a provider of Substance Abuse Case Management by DBHDS as defined in 12VAC35-105-1250.

"Substance use disorder" or "SUD" means a disorder, as defined in the DSM 5, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, tobacco, or other drugs despite significant related problems.

"Supervisees in social work" means professionals under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10).

"Telehealth" means the practice of the medical arts via electronic means rather than face-to-face.

"Tolerance" means, as defined by ASAM, a state of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drugs effects over time.

"Withdrawal management" means, as defined by ASAM, services to assist an individuals withdrawal from the use of substances.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-5050. Eligible individuals.

Children and adults who participate in Medicaid managed care plans and Medicaid fee for service and meet ASAM medical necessity criteria shall be eligible for ARTS, this shall include, notwithstanding the coverage limitations set forth in 12VAC30-135-450 and 12VAC30-135-469, adults in the Governors Access Plan for the Seriously Mental Ill (GAP SMI) (12 VAC 30-135-400 et seq.) who meet ASAM medical necessity criteria shall be eligible for ARTS with the exception of inpatient detoxification services (ASAM Level 4.0), substance use residential treatment (ASAM Levels 3.1 through 3.7), and substance use partial hospitalization (ASAM Level 2.5).

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12VAC30-130-5100. Covered services; requirements; limits; standards.

A. Addiction Recovery and Treatment Services (ARTS). These services, in order to be covered, (i) shall meet medical necessity criteria based upon the multidimensional assessment completed by a credentialed addiction treatment professional within the scope of their practice and (ii) are accurately reflected in provider medical record documentation and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. These ARTS services, with their service definitions, shall be covered: (i) Medically Managed Intensive Inpatient Services (ASAM Level 4); (ii) Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); (iii) Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5); (iv) Opioid Treatment Services ((Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT)); (v) Substance Use Outpatient Services (ASAM Level 1); (vi) Early Intervention Services (ASAM 0.5); (vii) Substance Use Care Coordination, (viii) Substance Use Case Management Services, and (ix) Withdrawal Management services shall be provided when medically necessary, as a component of the Medically Managed Inpatient Services (ASAM Level 4); Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7); Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5); Opioid Treatment Services (Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT); and Substance Use Outpatient Services (ASAM Level 1). ARTS services shall be fully integrated with all physical health and behavioral health services for a complete continuum of care for all Medicaid individuals meeting the medical necessity criteria. In order to receive reimbursement for ARTS services, the individual shall be enrolled in Virginia Medicaid and shall meet the following medical necessity criteria:

1. The individual shall demonstrate at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders with the exception of tobacco-related disorders or caffeine abuse or dependence and non-substance-related disorders; or be assessed to be

at risk for developing substance use disorder (for youth under the age of twenty-one using the ASAM multidimensional assessment).

2. The individual shall be assessed by a certified addiction treatment professional who will determine if he meets the severity and intensity of treatment requirements for each service level defined by the most current version of the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (Third Edition, 2013). Medical necessity for ASAM levels of care shall be based on the outcome of the individuals documented multidimensional assessment. The following outpatient ASAM levels of care do not require a complete multidimensional assessment using the ASAM theoretical framework to determine medical necessity but do require an assessment by a certified addiction treatment professional: Opioid Treatment Programs (OTP), Office Based Opioid Treatment (OBOT), and Substance Use Outpatient Services (ASAM Level 1).

3. For individuals younger than the age of 21 who do not meet the ASAM medical necessity criteria upon initial review, a second individualized review shall be conducted to determine if the individual needs medically necessary treatment under the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening.

B. Determination of medical necessity based on ASAM Criteria for addiction and recovery treatment services.

1. DMAS contracted managed care organizations (MCOs) and the BHSA shall employ or contract with licensed treatment professionals to apply the ASAM criteria to review and coordinate service needs when administering ARTS benefits.

2. The ARTS care coordinator or a licensed physician or medical director employed by the MCO or BHSA shall perform an independent assessment of requests for all ARTS residential treatment services (ASAM Levels 3.1, 3.3, 3.5, 3.7) and ARTS inpatient treatment services (ASAM Level 4.0).

3. Length of treatment and service limits shall be determined by the ARTS care coordinator employed by the BHSA or MCO who is applying the ASAM criteria.

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12VAC30-130-5120. Covered services: clinic services (OTP).

A. Settings for Opioid Treatment Program (OTP) services. The agency-based OTP provider shall be licensed by DBHDS and contracted by the BHSA or MCOs. Opioid Treatment Services are allowable in ASAM Levels 1.0 through 3.7 (excluding inpatient services). OTPs shall meet the service components, staff requirements, and risk management requirements.

B. OTP Service Components.

1. Linking the individual to psychological, medical, and psychiatric consultation as necessary to meet the individual's needs.

2. Access to emergency medical and psychiatric care through connections with more intensive levels of care.

3. Access to evaluation and ongoing primary care.

4. Ability to conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.

5. Licensed physicians are available to evaluate and monitor use of methadone, buprenorphine products or naltrexone products and of pharmacists and nurses to dispense and administer these medications.

6. Individualized, patient-centered assessment and treatment.

7. Ability to assess, order, administer, reassess, and regulate medication and dose levels appropriate to the individual; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.

8. Medication for other physical and mental health illness is provided as needed either on-site or through collaboration with other providers.

9. Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis.

10. Optional substance use care coordination that includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring individual progress and tracking individual outcomes; supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor individualized treatment plans; linking individuals with community resources to facilitate referrals and respond to social service needs; and tracking and supporting individuals when they obtain medical, behavioral health, or social services outside the practice.

11. Ability to refer for screening for infectious diseases such as HIV, hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

C. OTP Staff Requirements.

1. Staff requirements shall meet the licensing requirements of 12VAC35-105-925. The interdisciplinary team shall include credentialed addiction professionals trained in the treatment of opioid use disorder including an addiction credentialed physician and credentialed addiction treatment professionals as defined in 12VAC30-130-5020.

2. Staff shall be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders.

3. A physician or physician extender as defined in 12VAC30-130-5020, shall be available during medication dispensing and clinical operating hours, in-person or by telephone.

D. OTP risk management shall include and be clearly and adequately documented in each individual's record:

1. Random urine drug screening for all individuals, conducted at least eight times during a twelve month period as defined in 12VAC35-105-980.

2. The Virginia Prescription Monitoring Program shall be checked at least quarterly for all individuals.

3. Opioid overdose prevention education including the prescribing of naloxone.

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12VAC30-130-5121. Covered services: Clinic services (OBOT).

A. Office-based opioid treatment (OBOT) shall be provided by a buprenorphine-waivered practitioner and may be provided in a variety of practice settings including primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHCs), Community Service Boards/BHAs, local health department clinics, and physicians offices. The practitioner shall be contracted by the BHSA or MCO to perform OBOT services. OBOT services shall meet the following criteria.

1. OBOT service components.

a. Access to emergency medical and psychiatric care.

b. Affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs that unstable individuals can be referred to when clinically indicated.

c. Individualized, patient-centered assessment and treatment.

d. Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual; supervising withdrawal management from opioid analgesics; overseeing and facilitating access to appropriate treatment for opioid use disorder and alcohol use disorder.

e. Medication for other physical and mental illnesses shall be provided as needed either on-site or through collaboration with other providers.

f. Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, shall be provided to the individual on an individual, group, or family basis and shall be provided by credentialed addiction treatment professionals working in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with moderate to severe opioid use disorder. These therapies can be provided via telehealth as long as they meet the Department's requirements for an OBOT and for the use of telehealth. (See the Medicaid Memo entitled "Updates to Telemedicine Coverage" dated May 13, 2014.)

g. Substance use care coordination provided including interdisciplinary care planning between buprenorphine-waivered physician and the licensed behavioral health provider to develop and monitor individualized and personalized treatment plans focused on the best outcomes for the individual. This care coordination includes monitoring individual progress, tracking individual outcomes, linking individual with community resources to facilitate referrals and respond to social service needs, and tracking and supporting the individual's medical, behavioral health, or social services received outside the practice.

h. Referral for screening for infectious diseases such as HIV, hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

B. OBOT staff requirements.

1. Buprenorphine-waivered practitioner licensed under Virginia law who has completed one of the continuing medical education courses approved by the Center for Substance Abuse Treatment and obtained the waiver to prescribe or dispense buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (DATA 2000). The practitioner must have a DEA-X number

issued by the Drug Enforcement Agency that is included on all buprenorphine prescriptions for treatment of opioid use disorder.

2. Credentialed addiction treatment professionals shall work in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with moderate to severe opioid use disorder. This collaboration can be in-person or via telemedicine as long as it meets the departments requirements for the OBOT setting and for telehealth.

C. OBOT risk management shall include and shall be documented in each individuals record:

1. Random urine drug screening for all individuals, conducted at a minimum of eight times per year.

2. The Virginia Prescription Monitoring Program shall be checked at least quarterly for all individuals.

3. Opioid overdose prevention education including the prescribing of naloxone.

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12VAC30-130-5140. Covered services: practitioner services Early Intervention/Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5).

A. Early intervention (ASAM Level 0.5) settings for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services shall include health care settings including: local health departments, FQHCs, rural health clinics (RHCs), Community Services Boards (CSBs)/BHAs, health systems, emergency departments, pharmacies, physician offices, and outpatient clinics. These providers shall be licensed by DHP and either directly contracted by the BHSA or MCOs to perform this level of care, or employed by organizations that are contracted by the BHSA or MCO.

B. Early intervention/SBIRT (ASAM Level 0.5) service components shall include:

1. Identifying individuals who may have alcohol or other substance use problems using an evidence-based screening tool.

2. Following the evidence-based screening tool, a brief intervention by a licensed clinician shall be provided to educate individuals about substance use, alert these individuals to possible consequences and, if needed, begin to motivate individuals to take steps to change their behaviors.

C. Early intervention/SBIRT (ASAM Level 0.5) staff requirements. Physicians, pharmacists, and other credentialed addiction treatment professionals shall administer the evidence-based screening tool with the individual and provide the counseling and intervention. Licensed providers may delegate administration of the evidence-based screening tool to other clinical staff as allowed by their scope of practice, such as physicians delegating administration of the tool to a licensed registered nurse or licensed practical nurse, but the licensed provider shall review the tool with the individual and provide the counseling and intervention.

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12VAC30-130-5141. Covered services (physician services (ASAM 1).

A. Outpatient services (ASAM Level 1). These services shall be provided by a credentialed addiction treatment professional, psychiatrist, or physician contracted by the BHSA or MCO to perform these services in the following community based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, FQHCs, Community Service Boards/BHAs, local health departments, physician and provider offices. Reimbursement for substance use outpatient services shall be made for medically necessary services provided in accordance with an ISP or the treatment plan and include withdrawal management as necessary. Services can be provided face-to-face or by telehealth. Outpatient services shall meet the ASAM Level 1 service components and staff requirements as follows.

1. Outpatient services (ASAM Level 1) service components.

a. Substance use outpatient services shall be provided fewer than nine hours per week and may be delivered in the following health care settings: local health departments, FQHCs , rural health clinics (RHC), Community Services Boards (CSB)/BHAs, health systems, emergency departments, physician and provider offices, and outpatient clinics. If services are provided in a setting other than the office or a clinic, as defined in this subsection, this shall be documented. Services shall include professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.

b. A multidimensional assessment shall be used and shall be documented to determine that an individual meets the medical necessity criteria and shall include the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. The multidimensional assessment shall include a physical examination and laboratory testing necessary for substance use disorder treatment as necessary.

c. Individual counseling between the individual and a credentialed addiction treatment professional shall be provided. Services provided face-to-face or by telehealth shall qualify as reimbursable.

d. Group counseling by a credentialed addiction treatment professional, with a maximum of 10 individuals in the group shall be provided. Such counseling shall focus on the needs of the individuals served.

e. Family therapy shall be provided to facilitate the individuals recovery and support for the familys recovery.

f. Evidenced-based patient education on addiction, treatment, recovery and associated health risks shall be provided.

g. Medication services shall be provided including the prescription of or administration of medication related to substance use treatment, or the assessment of the side effects or results of that medication. Medication services shall be provided by staff lawfully authorized to provide such services and they shall order laboratory testing within their scope of practice or licensure.

h. Collateral services shall be provided.

B. Outpatient services (ASAM Level 1) staff requirements shall include:

1. Credentialed addiction treatment professional; or

2. A registered nurse or a practical nurse who is licensed by the Commonwealth (18VAC90-2010 et seq.) with at least one year of clinical experience involving medication management.

C. Outpatient services (ASAM Level 1) co-occurring enhanced programs shall include:

1. Ongoing substance use case management for highly crisis prone individuals with co-occurring disorders.

2. Credentialed addiction treatment professionals who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor and manage individuals who have a co-occurring mental health disorder.

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12VAC30-130-5160. Covered services: community based services - Intensive Outpatient Services (ASAM Level 2.1).

A. Intensive outpatient services (ASAM Level 2.1) shall be a structured program of skilled treatment services for adults, children and adolescents delivering a minimum of 3 service hours per service day to achieve 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for children and adolescents. Withdrawal management services may be provided as necessary. The following service components shall be provided weekly as directed by the ISP for reimbursement:

1. Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral.

2. Psychiatric and other individualized treatment planning.

3. Individual and group counseling, medication management, family therapy, and psychoeducation.

4. Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies, to inspire an individual's motivation to change behaviors.

5. Psychiatric and medical consultation, which shall be available within 24 hours of the requested consult by telephone and preferably within 72 hours of the requested consult in person or via telehealth.

6. Psycho-pharmacological consultation.

7. Addiction medication management and 24-hour crisis services.

8. Medical, psychological, psychiatric, laboratory, and toxicology services.

B. Intensive outpatient services (ASAM Level 2.1) shall be provided by agency-based providers that shall be licensed by DBHDS as a Substance Abuse Intensive Outpatient Service for Adults, Children, and Adolescents and contracted with the BHSA or MCO to provide this service. Intensive outpatient service providers shall meet the ASAM Level 2.1 service components and staff requirements as follows:

1. Interdisciplinary team of credentialed addiction treatment professionals shall be required.

2. Generalist physicians or physicians with experience in addiction medicine are permitted to provide general medical evaluations and concurrent/integrated general medical care.

3. Staff shall be cross-trained to understand signs and symptoms of psychiatric disorders and be able to understand and explain the uses of psychotropic

medications and understand interactions with substance use and other addictive disorders.

4. Emergency services, which shall be available, when necessary, by telephone 24 hours per day and seven days per week when the treatment program is not in session.

5. Direct affiliation with (or close coordination through referrals to) higher and lower levels of care and supportive housing services.

C. Intensive outpatient services (ASAM Level 2.1) co-occurring enhanced programs.

1. Co-occurring capable programs offer these therapies and support systems in intensive outpatient services described above to individuals with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a planned program of therapies.

2. Individuals who are not able to benefit from a full program of therapies, will be offered enhanced program services to match the intensity of hours in ASAM Level 2.1, including substance use case management, assertive community treatment, medication management and psychotherapy.

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12VAC30-130-5161. Community based care: Partial Hospitalization Services (ASAM Level 2.5).

A. Partial hospitalization service (ASAM Level 2.5) components.

1. Partial hospitalization service components shall include the following, as defined in the ISP and provided on a weekly basis:

a. Individualized treatment planning;

b. A minimum of 20 hours per week and at least five service hours per service day of skilled treatment services with a planned format including individual and group counseling, medication management, family therapy, education groups, occupational and recreational therapy and other therapies. Withdrawal management services may be provided as necessary. Time not spent in skilled, clinically intensive treatment is not billable.

c. Family therapies involving family members, guardians, or significant other in the assessment, treatment, and continuing care of the individual.

d. A planned format of therapies, delivered in individual or group settings.

e. Motivational interviewing, enhancement, and engagement strategies.

B. Partial hospitalization services (ASAM Level 2.5). The substance use partial hospitalization service provider shall be licensed by DBHDS as a Substance Abuse Partial Hospitalization program or Substance Abuse/Mental Health Partial Hospitalization program and contracted with the BHSA or MCO. Partial hospitalization service providers shall meet the ASAM Level 2.5 support systems and staff requirements as follows:

1. Interdisciplinary team comprised of credentialed addiction treatment professionals and an addiction-credentialed physician, or physician with

experience in addiction medicine, or physician extenders as defined in 12VAC30-130-5020, shall be required.

2. Physicians shall have specialty training or experience, or both, in addiction medicine or addiction psychiatry. Physicians who treat adolescents shall have experience with adolescent medicine.

3. Program staff shall be cross-trained to understand signs and symptoms of mental illness and be able to understand and explain the uses of psychotropic medications and understand interactions with substance use and other addictive disorders.

4. Medical, psychological, psychiatric, laboratory, and toxicology services, which are available by consult or referral.

5. Psychiatric and medical formal agreements to provide medical consult within eight hours of the requested consult by telephone, or within 48 hours in person or via telehealth.

6. Emergency services are available 24-hours a day and seven days a week.

7. Direct affiliation with or close coordination through referrals to higher and lower levels of care and supportive housing services.

C. Partial hospitalization services (ASAM Level 2.5) co-occurring enhanced programs shall offer:

1. Therapies and support systems as described above to individuals with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a full program of therapies. Other individuals who are not able to benefit from a full program of therapies (who are severely or chronically mentally ill) will be offered enhanced program services to constitute intensity of hours in Level 2.5, including substance use case management, assertive community treatment, medication management, and psychotherapy.

2. Psychiatric services as appropriate to meet the individual's mental health condition. Services may be available by telephone and on site, or closely coordinated off site, or via telehealth within a shorter time than in a co-occurring capable program.

3. Clinical leadership and oversight and, at a minimum, capacity to consult with an addiction psychiatrist via telephone, telemedicine, or in person.

4. Credentialed addiction treatment professionals with experience assessing and treating co-occurring mental illness.

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12VAC30-130-5180. Covered services: Clinically Managed Low Intensity Residential Services (ASAM Level 3.1).

A. Clinically managed low intensity residential services (ASAM Level 3.1).

1. The agency-based residential group home services (ASAM Level 3.1) shall be licensed by DBHDS as a Mental Health & Substance Abuse Group Home Service for Adults or Children or licensed by DBHDS as a Substance Abuse Halfway House for Adults and contracted by the BHSA or MCO. Clinically directed program activities (constituting at least five hours per week of professionally directed treatment shall be designed to stabilize and maintain substance use disorder symptoms, and to develop and apply recovery skills. Activities shall include

relapse prevention, interpersonal choice exploration, development of social networks in support of recovery. This service shall not include settings where clinical treatment services are not provided. ASAM Level 3.1 clinically managed low intensity residential service providers shall meet the service components and staff requirements as noted in this section.

B. Clinically managed low intensity residential services (ASAM Level 3.1) service components.

1. Physician consultation and emergency services, which shall be available 24 hours a day and seven days per week.

2. Arrangements for medically necessary procedures including laboratory and toxicology tests, which are appropriate to the severity and urgency of an individual's condition.

3. Arrangements for pharmacotherapy for psychiatric or anti-addiction medications.

4. Arrangements for higher and lower levels of care and other services.

C. The following services shall be provided as directed by the ISP:

1. Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and re-integration of the individual into the network systems of work, education, and family life;

2. Addiction pharmacotherapy and drug screening;

3. Motivational enhancement and engagement strategies;

4. Counseling and clinical monitoring;

5. Regular monitoring of the individual's medication adherence;

6. Recovery support services;

7. Services for the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP, and;

8. Education on benefits of medication assisted treatment and referral to treatment as necessary.

D. Clinically managed low intensity residential services (ASAM Level 3.1) staff requirements.

1. Allied health professionals shall be available on-site 24-hours a day or as required by DBHDS licensing regulations.

2. Clinical staff who are experienced and knowledgeable about the biopsychosocial and psychosocial dimensions and treatment of substance use disorders. Clinical staff shall be able to identify the signs and symptoms of acute psychiatric conditions and decompensation.

3. An addiction-credentialed physician or physician with experience in addiction medicine shall review the residential group home admission to confirm medical necessity for services, and a team of credentialed addiction treatment professionals shall develop and shall ensure delivery of the ISP.

4. Coordination with community physicians to review treatment as needed.

5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

E. Clinically managed low intensity residential services (ASAM Level 3.1) co-occurring enhanced programs as required by ASAM.

1. In addition to the Level 3.1 service components listed in this section, programs for individuals with both unstable substance use and psychiatric disorders shall offer appropriate psychiatric services, including medication evaluation and laboratory services. Such services are provided either on-site, via telehealth, or closely coordinated with an off-site provider, as appropriate to the severity and urgency of the individuals mental health condition.

2. Certified addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental illness, and understand and be able to explain to the individual the purpose of psychotropic medications and interactions with substance use.

3. The therapies described in this section shall be offered as well as planned clinical activities (either on-site or with an off-site provider) that are designed to stabilize and maintain the individuals mental health program and psychiatric symptoms.

4. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental illness.

5. Medication education and management shall be provided.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-5200. Covered services: Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3).

A. Clinically managed population-specific high intensity residential service (ASAM Level 3.3). The facility-based provider shall be licensed by DBHDS to provide supervised residential treatment services for adults or licensed by DBHDS to provide Substance Abuse Residential Treatment for Adults, Supervised Residential Treatment Services for Adults, or Substance Abuse and Mental Health Residential Treatment Services for Adults, and contracted by the BHSA or MCO. ASAM Level 3.3 settings do not include sober houses, boarding houses, or group homes where treatment services are not provided. Residential treatment service providers for clinically managed population-specific high intensity residential service (ASAM Level 3.3) shall meet these service components and staff requirements.

B. Clinically managed population-specific high intensity residential service (ASAM Level 3.3) service components.

1. Clinically managed population-specific high intensity residential service components shall include:

a. Access to consulting physician or physician extender and emergency services 24 hours a day and seven days a week;

b. Arrangements for higher and lower levels of care;

c. Arrangements for laboratory and toxicology services appropriate to the severity of need, and;

d. Arrangements for addiction pharmacotherapy.

2. The following therapies shall be provided as directed by the ISP for reimbursement:

a. Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life;

b. Addiction pharmacotherapy and drug screening;

c. Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the individual in initial involvement or re-engagement in regular productive daily activity;

d. Recreational therapy, art, music, physical therapy and vocational rehabilitation;

e. Motivational enhancement and engagement strategies;

f. Regular monitoring of the individual's medication adherence;

g. Recovery support services;

h. Services for the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP;

i. Education on benefits of medication assisted treatment and referral to treatment as necessary, and;

j. Withdrawal management services may be provided as necessary.

C. Clinically managed population-specific high intensity residential service (ASAM Level 3.3) staff requirements.

1. The interdisciplinary team shall include credentialed addiction treatment professionals, physicians, or physician extenders and allied health professionals in an interdisciplinary team.

2. Staffed by allied health professionals as required by DBHDS licensing standards.

3. Clinical staff who are experienced and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders and who are available on-site or by telephone 24 hours per day. Clinical staff shall be able to identify acute psychiatric conditions and decompensation.

4. Substance use case management is included in this level of care.

5. Appropriately credentialed medical staff shall be available to assess and treat co-occurring biomedical disorders and to monitor the individual's administration of prescribed medications.

D. Clinically managed population-specific high intensity residential service co-occurring enhanced programs, as required by ASAM.

1. Appropriate psychiatric services, including medication evaluation and laboratory services shall be provided on-site or through a closely coordinated off-site provider, as appropriate to the severity and urgency of the individual's mental condition.

2. Psychiatrists and credentialed addiction treatment professionals shall be available to assess and treat co-occurring substance use and mental illness using specialized training in behavior management techniques.

3. Credentialed addiction treatment professionals shall be cross-trained in addiction and mental health to understand the signs and symptoms of mental

illness, and be able to provide education to the individual on the interactions with substance use and psychotropic medications.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-5201. Covered Services. Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5).

A. Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) settings for services. This facility based residential treatment service provider (ASAM Level 3.5) shall be licensed by DBHDS as a Substance Abuse Residential Treatment Services for Adults or Children, a Psychiatric Unit, or a Substance Abuse and Mental Health Residential Treatment Services for Adults and Children and shall be contracted by the BHSA or MCO. Residential treatment providers (ASAM Level 3.5) shall meet the service components and staff requirements in this section.

B. Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) service components.

1. These residential treatment services, as required by ASAM, include:

a. Telephone or in-person consultation with a physician or physician-extender who shall be available to perform required physician services. Emergency services shall be available 24 hours per day and seven days per week;

b. Arrangements for more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education;

c. Arrangements for needed procedures including medical, psychiatric, psychological, lab and toxicology services appropriate to the severity of need, and;

d. Arrangements for addiction pharmacotherapy.

2. The following therapies shall be provided as directed by the ISP for reimbursement:

a. Clinically directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. Activities shall be designed to stabilize and maintain substance use disorder symptoms and apply recovery skills and may include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.

b. Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the individual in initial involvement or re-engagement in regular productive daily activities including education on medication management, addiction pharmacotherapy, and education skill building groups to enhance the individual's understanding of substance use and mental illness.

c. Addiction pharmacotherapy and drug screening.

d. Recreational therapy, art, music, physical therapy, and vocational rehabilitation.

e. Motivational enhancements and engagement strategies.

f. Monitoring the adherence to prescribed medications and over-the-counter medications and supplements.

g. Daily scheduled professional services and interdisciplinary assessments and treatment designed to develop and apply recovery skills.

h. Services for family and significant others, as appropriate, to advance the individual's treatment goals and objectives identified in the ISP.

i. Education on benefits of medication assisted treatment and referral to treatment as necessary.

j. Withdrawal management services may be provided as necessary.

C. Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) staff requirements.

1. The interdisciplinary team shall include credentialed addiction treatment professionals, physicians, or physician extenders and allied health professionals.

2. Staffed by allied health professionals and clinical staff as required by DBHDS licensing standards.

3. Clinical staff who are experienced in and knowledgeable about the biopsychosocial dimensions and treatment of substance use disorders. Clinical staff shall be able to identify acute psychiatric conditions and decompensations.

4. Substance use case management shall be provided in this level of care.

5. Appropriately credentialed medical staff shall be available on-site or by telephone 24 hours per day, seven days per week to assess and treat co-occurring biological and physiological disorders and to monitor the individual's administration of medications in accordance with a physician's prescription.

D. Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs as required by ASAM.

1. Psychiatric services, medication evaluation, and laboratory services shall be provided. Such services shall be available by telephone within eight hours of requested service and on-site or via telemedicine, or closely coordinated with an off-site provider within 24 hours of requested service, as appropriate to the severity and urgency of the individuals mental and physical condition.

2. Staff shall be credentialed addiction treatment professionals who are able to assess and treat co-occurring substance use and psychiatric disorders.

3. Planned clinical activities shall be required and shall be designed to stabilize and maintain the individuals mental health problems and psychiatric symptoms.

4. Medication education and management shall be provided.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-5202. Covered Services: Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7).

A. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) settings for

services. The facility-based providers of ASAM Level 3.7 services shall be licensed by DBHDS as an Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License, a Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Medical Detoxification License, or a Residential Crisis Stabilization Unit with DBHDS Medical Detoxification License, and shall be contracted by the BHSA or the MCO. ASAM Level 3.7 providers shall meet the service components and staff requirements in this section.

B. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) service components. The following therapies shall be provided as directed by the ISP for reimbursement:

1. Daily clinical services provided by an interdisciplinary team to involve appropriate medical and nursing services, as well as individual, group and family activity services. Activities may include pharmacological, withdrawal management, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the individual's level of understanding and assist in the individual's recovery.

2. Counseling and clinical monitoring to facilitate re-involvement in regular productive daily activities and successful re-integration into family living if applicable.

3. Random drug screens to monitor use and strengthen recovery and treatment gains.

4. Regular medication monitoring.

5. Planned clinical activities to enhance understanding of substance use disorders.

6. Health education associated with the course of addiction and other potential health related risk factors including Tuberculosis, HIV, Hepatitis B and C, and other sexually transmitted Infections.

7. Evidence based practices such as motivational interviewing to address the individuals readiness to change, designed to facilitate understanding of the relationship of the substance use disorder and life impacts.

8. Daily treatments to manage acute symptoms of biomedical substance use or mental illness.

9. Services to family and significant others as appropriate to advance the individual's treatment goals and objectives identified in the ISP.

10. Physician monitoring, nursing care and observation shall be available. A physician shall be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary.

11. A registered nurse shall conduct an alcohol or other drug focused nursing assessment upon admission. A licensed registered nurse or licensed practical nurse shall be responsible for monitoring the individual's progress and for medication administration duties.

12. Additional medical specialty consultation, psychological, laboratory and toxicology services shall be available on site, either through consultation or referral.

13. Coordination of necessary services shall be available on-site or through referral to a closely coordinated off-site provider to transition the individual to lower levels of care.

14. Psychiatric services shall be available on-site or through consultation or referral to a closely coordinated off-site provider when a presenting problem could be attended to at a later time. Such services shall be available within eight hours of requested service by telephone or within 24 hours of requested service in-person or via telehealth.

C. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) staff requirements.

1. The interdisciplinary team shall include credentialed addiction treatment professionals and addiction-credentialed physicians or physicians with experience in addiction medicine to assess, treat, obtain and interpret information regarding the individual's psychiatric and substance use disorders.

2. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental illnesses and their treatment. Clinical staff shall be able to identify acute psychiatric conditions, symptom increase or escalation, and decompensation.

3. Clinical staff shall be able to provide a planned regimen of 24 hour professionally directed evaluation, care and treatment including the administration of prescribed medications.

4. Addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure quality of care. Licensed physicians shall perform physical examinations for all individuals who are admitted. Staff shall supervise addiction pharmacotherapy, integrated with psychosocial therapies. The professional may be a physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020 if knowledgeable about addiction treatment.

D. Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs as required by ASAM.

1. Appropriate psychiatric services, medication evaluation, and laboratory services shall be available.

2. A psychiatrist assessment of the individual shall occur within four hours of admission by telephone and within 24 hours following admission in person or via telehealth, or sooner, as appropriate to the individual's behavioral health condition, and thereafter as medically necessary.

3. A behavioral health-focused assessment at the time of admission shall be performed by a registered nurse or licensed mental health clinician. A licensed registered nurse or licensed practical nurse supervised by a registered nurse shall be responsible for monitoring the individuals progress and administering or monitoring the individuals self-administration of medications.

4. Psychiatrists and credentialed addiction treatment professionals who are able to assess and treat co-occurring psychiatric disorders and who have specialized training in the behavior management techniques and evidenced-based practices shall be available.

5. Access to an addiction-credentialed physician shall be available along with access to either a psychiatrist, a certified addiction psychiatrist, or a psychiatrist with experience in addiction medicine.

6. Credentialed addiction treatment professionals shall have experience and training in addiction and mental health to understand the signs and symptoms of

mental illness, and be able to provide education to the individual on the interaction of substance use and psychotropic medications.

7. Planned clinical activities shall be offered and designed to promote stabilization and maintenance of the individuals behavioral health needs, recovery, and psychiatric symptoms.

8. Medication education and management shall be offered.

THE TEXT OF THIS REGULTION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-5220. Covered services: Medically Managed Intensive Inpatient Services (ASAM Level 4.0).

A. Medically managed intensive inpatient services (ASAM Level 4.0) settings for services. Acute care hospitals licensed by the Virginia Department of Health shall be the designated setting for medically managed intensive inpatient treatment and shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs. Such service settings shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress, or all of these, resulting from, or co-occurring with, an individual's use of alcohol or other drugs with the exception of tobacco-related disorders, caffeine abuse or dependence, or non-substance-related disorders.

B. Medically managed intensive inpatient services (ASAM Level 4.0) service components.

1. The service components of medically managed intensive inpatient services shall be:

a. An evaluation or analysis of substance use disorders shall be provided, including the diagnosis of substance use disorders and the assessment of treatment needs for medically necessary services.

b. Observation and monitoring the individuals course of withdrawal shall be provided. This shall be conducted as frequently as deemed appropriate for the individual and the level of care the individual is receiving. This may include, for example, observation of the individuals health status.

c. Medication services including the prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by appropriate licensed staff who provide such services within their scope of practice or license.

2. The following therapies shall be provided for reimbursement:

a. Daily clinical services provided by an interdisciplinary team to stabilize acute addictive or psychiatric symptoms. Activities shall include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the individual's level of understanding. For individuals with a severe biomedical disorder, physical health interventions are available to supplement addiction treatment. For the individual who has less stable psychiatric symptoms, Level 4 co-occurring capable programs offer individualized treatment activities designed to monitor the individual's mental health and to address the interaction of the mental health programs and substance use disorders.

b. Health education services.

c. Planned clinical interventions that are designed to enhance the individual's understanding and acceptance of illness of addiction and the recovery process.

d. Services for the individual's family, guardian, or significant other, as appropriate, to advance the individual's treatment and recovery goals and objectives identified in the ISP.

e. This level of care offers 24-hour nursing care and daily physician care for severe, unstable problems in any of the following ASAM dimensions: i) acute intoxication or withdrawal potential; ii) biomedical conditions and complications; iii) emotional, behavioral, or cognitive conditions and complications.

f. Discharge services shall be the process to prepare the individual for referral into another level of care, post treatment return or reentry into the community, or the linkage of the individual to essential community treatment, housing, recovery, and human services.

C. Medically managed intensive inpatient services (ASAM Level 4.0) staff requirements.

1. An interdisciplinary staff of appropriately credentialed clinical staff including, for example, addiction-credentialed physicians or physicians with experience in addiction medicine, licensed nurse practitioners, licensed physician assistants, registered nurses, licensed professional counselors, licensed clinical psychologists, or licensed clinical social workers who assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or behavioral disorders.

2. Medical management by physicians and primary nursing care shall be available 24 hours per day and counseling services shall be available 16 hours per day.

D. Medically managed intensive inpatient services (ASAM Level 4.0) co-occurring enhanced programs. These programs shall be provided by appropriately credentialed mental health professionals who assess and treat the individual's co-occurring mental illness and are knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and their treatment.

Form: TH-04
11/14

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Fast-Track Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation(s)	Addiction and Recovery Treatment Services (ARTS) (12 VAC 30 – 130- 5000 et seq.); Chapter 50 Amount, Duration, and Scope of Services: Inpatient Hospital Services (12 VAC 30-50-100); Outpatient Hospital, FQHCs and RHCs (12 VAC 30-50-110); EPSDT (12 VAC 30-50-130); Physician Services (12 VAC 30-50-140); Other Practitioners (12 VAC 30-50-150); Clinic Services (12 VAC 30-50-180); Substance Use Disorder Case Management (12 VAC 30-50-491); Expanded Prenatal Care (12 VAC 30-50-510); Chapter 60: Utilization control Substance Use Treatment (12 VAC 30-60-181); Utilization control Case Management (12 VAC 30-60-185); Chapter 70 Inpatient Hospital Reimbursement (12 VAC 30-70-201, 12 VAC 30-70-415; 12 VAC 30-70-417); Chapter 80 Reimbursement for Other Provider Types: Substance abuse services (12 VAC 30-80-32); REPEALED: Chapter 50 Amount, Duration, and Scope of Services Community Substance Abuse Treatment Services (12 VAC 30-50-228); Chapter 60: Substance Abuse Treatment Services and Case Management Utilization Control (12 VAC 30-60-147 and 12 VAC 30-60-180); Chapter 130 Community Mental Health Mental Retardation Services (12 VAC 30-130-540 through 12 VAC 30-130-590)
Regulation title(s)	Amount, Duration, and Scope of Selected Services
Action title	Addiction and Recovery Treatment Services (ARTS)
Date this document prepared	November 14, 2016

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.

The Department of Medical Assistance Services is proposing a new program, called Addiction and Recovery Treatment Services (ARTS), which will provide a comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. This will include: (i) inpatient withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv) intensive outpatient treatment; (v) outpatient treatment including Medication Assisted Treatment (MAT); and (vi) peer recovery supports. Providers will be credentialed and trained to deliver these services consistent with ASAM's published criteria and using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

These new and revised services will be offered through Medicaid managed care organizations as well as via the fee-for-service delivery system to promote the full integration of coordinated physical health, traditional mental health, and addiction treatment services. DMAS will be administering these services under the authority of the State Plan for Medical Assistance and a federal demonstration waiver (the *Social Security Act* § 1115). DMAS submitted its waiver application to the Centers for Medicare and Medicaid Services on August 5, 2016.

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 Addiction and Recovery Treatment Services (ARTS) with the attached amended regulations Addiction and Recovery Treatment Services (ARTS) (12 VAC 30 – 130- 5000 et seq.); Chapter 50 Amount, Duration, and Scope of Services: Inpatient Hospital Services (12 VAC 30-50-100); Outpatient Hospital, FQHCs and RHCs (12 VAC 30-50-110); EPSDT (12 VAC 30-50-130); Physician Services (12 VAC 30-50-140); Other Practitioners (12 VAC 30-50-150); Clinic Services (12 VAC 30-50-180); Substance Use Disorder Case Management (12 VAC 30-50-491); Expanded Pre-natal Care (12 VAC 30-50-510); Chapter 60: Utilization control Substance Use Treatment (12 VAC 30-60-181); Utilization control Case Management (12 VAC 30-60-185); Chapter 70 Inpatient Hospital Reimbursement (12 VAC 30-70-201, 12 VAC 30-70-415; 12 VAC 30-70-417); Chapter 80 Reimbursement for Other Provider Types: Substance abuse services (12 VAC 30-80-32); REPEALED: Chapter 50 Amount, Duration, and Scope of Services Community Substance Abuse Treatment Services (12 VAC 30-50-228); Chapter 60: Substance Abuse Treatment Services and Case Management Utilization Control (12 VAC 30-60-147 and 12 VAC 30-60-180); Chapter 130 Community Mental Health Mental Retardation Services (12 VAC 30-130-540

through 12 VAC 30-130-590) and adopt the action stated therein. I certify that this fast track regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012.1, of the Administrative Process Act.

Date

Cynthia B. Jones, Director

Dept. of Medical Assistance Services

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.

ARTS means the Addiction and Recovery Treatment Services.
ASAM means the American Society of Addiction Medicine.
BHSA (Magellan) means the Behavioral Health Services Administrator contracted with DMAS.
CSB/BHA" means Community Services Board or Behavioral Health Authority.
DSM means the Diagnostic and Statistical Manual.
EPSDT means Early and Periodic Screening, Diagnosis and Treatment services.
IMDs means Institutions for Mental Disease.
FQHCs means Federally Qualified Healthcare Centers which are typically located in medically underserved areas of the Commonwealth.
LOC means level of care.
MAT means Medication Assisted Treatment
NCQA means the National Committee for Quality Assurance.
PCP means the primary care physician.
SBIRT means Screening, Brief Intervention and Referral to Treatment.
SUD means substance use disorder.

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, 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 *2016 Acts of the Assembly*, Chapter 780, Item 306 MMMM directed:

1. "The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall amend the state plan for medical assistance and/or seek federal authority through an 1115 demonstration waiver, as soon as feasible, to provide coverage of inpatient detoxification, inpatient substance abuse treatment, residential detoxification, residential substance abuse treatment, and peer support services to Medicaid individuals in the Fee-for-Service and Managed Care Delivery Systems. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change."

2. "The Department of Medical Assistance Services shall make programmatic changes in the provision of all Substance Abuse Treatment Outpatient, Community Based and Residential Treatment services (group homes and facilities) for individuals with substance abuse disorders in order to ensure parity between the substance abuse treatment services and the medical and mental health services covered by the department and to ensure comprehensive treatment planning and care coordination for individuals receiving behavioral health and substance use disorder services. The department shall take action to ensure appropriate utilization and cost efficiency, and adjust reimbursement rates within the limits of the funding appropriated for this purpose based on current industry standards. The department shall consider all available options including, but not limited to, service definitions, prior authorization, utilization review, provider qualifications, and reimbursement rates for the following Medicaid services: substance abuse day treatment for pregnant women, substance abuse residential treatment for pregnant women, substance abuse case management, opioid treatment, substance abuse day treatment, and substance abuse intensive outpatient. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change."

3. "The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance and any waivers thereof to include peer support services to children and adults with mental health conditions and/or substance use disorders. The department shall work with its contractors, the Department of Behavioral Health and Developmental Services, and appropriate stakeholders to develop service definitions, utilization review criteria and provider qualifications. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change."

4. "The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance shall, prior to the submission of any state plan amendment or waivers to implement paragraphs MMMM 1, MMMM 2, and MMMM 3, submit a plan detailing the changes in provider rates, new services added and any other programmatic changes to the Chairmen of the House Appropriations and Senate Finance Committees."

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 Commonwealth is currently experiencing a crisis of substance use of overwhelming proportions. More Virginians died from drug overdose in 2013 than from automobile accidents. In 2014, 80% of the people who died from drug overdoses (986 people) died from prescription opioid or heroin overdoses. Virginia's 1.1 million Medicaid/FAMIS members are affected disproportionately by this substance use epidemic as demonstrated by DMAS' claims history data showing 216,555 Medicaid members with a substance use diagnosis in state fiscal year 2015. This regulatory action has a direct, specific impact on the health, safety, and welfare of the Commonwealth's Medicaid individuals.

This action implements a comprehensive program of community-based addiction and recovery treatment services in response to the Governor's bipartisan Task Force on Prescription Drug and Heroin Addiction's numerous recommendations. A major recommendation of this Task Force was to increase access to treatment for opioid addiction for the Commonwealth's Medicaid members by increasing Medicaid reimbursement rates for these services, because data shows that these individuals are being disproportionately impacted by the substance use epidemic.

Rationale for using fast-track process

Please ***explain the rationale for using the fast-track process*** *in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?*

This regulatory action is being promulgated as a fast track action because public comments received about the general concept and features which have been specified to date have been positive. The comprehensive ARTS proposal is such a substantial improvement over the current fragmented approach to substance use treatment that the affected entities are actively participating with DMAS in its redesign and transformation efforts.

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 regulations affected by this action are the newly created Addiction and Recovery Treatment Services (ARTS) (12 VAC 30-130-5000 et seq.) Sections of the State Plan for Medical Assistance (and related regulations) recommended for modification or repeal are as follows

Chapter 50 Amount, Duration, and Scope of Services: Inpatient Hospital Services (12 VAC 30-50-100); EPSDT (12 VAC 30-50-130); Physician Services (12 VAC 30-50-140); Other Practitioners (12 VAC 30-50-150); Clinic Services (12 VAC 30-50-180); Axis I Case Management (12 VAC 30-50-491); Expanded Pre-natal Care (12 VAC 30-50-510); Chapter 60: Utilization control Freestanding Psychiatric Hospital services (12 VAC 30-60-25); Utilization control Substance Use Treatment (12 VAC 30-60-147); Utilization control Community Substance Use Treatment (12 VAC 30-60-180); Utilization control Case Management (12 VAC 30-60-185); Chapter 80: Inpatient Psychiatric Services in Residential Treatment Facilities under EPSDT (12 VAC 30-80-21); Reimbursement for Substance Abuse Services (12 VAC 30-80-32); Chapter 130 Community Mental Health Mental Retardation Services (12 VAC 30-130-540 through 12 VAC 30-130-590) (REPEALED).

CURRENT POLICY

DMAS covers approximately 1.1 million individuals: 80% of members receive care through contracted managed care organizations (MCOs) and 20% of members receive care through fee-for-service (FFS). The majority of members enrolled in Virginia's Medicaid and FAMIS programs include children, pregnant women, and individuals who meet the disability category of being aged, blind, or disabled. The 20% of the individuals receiving care through fee for service do so because they meet one of 16 categories of exception to MCO participation, for example: (i) inpatients in state mental hospitals, long-stay hospitals, nursing facilities, or ICF/IIDs; (ii) individuals on spend down; (iii) individuals younger than 21 years of age who are in residential treatment facility Level C programs; (iv) newly eligible individuals in their third trimester of pregnancy; (v) individuals who permanently live outside their area of residence; (vi) individuals receiving hospice services; (vii) individuals with other comprehensive group or individual health insurance; (viii) individuals eligible for Individuals with Disabilities Education Act (IDEA) Part C services; (ix) individuals whose eligibility period is less than 3 months or is retroactive, and; (x) individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program.

Historically, Virginia funded only limited kinds of substance use treatment services to limited populations of Medicaid eligible individuals (for example, pregnant women and children). The Commonwealth now has compelling reasons to provide Medicaid coverage for the identification and treatment of substance use disorders: individuals with substance use disorders and co-morbid medical conditions account for high Medicaid costs. Beyond health care risk, the economic costs associated with substance use disorders are significant. States and the federal government spend billions of tax dollars every year on the collateral impact associated with substance use disorders, including criminal justice, public assistance and lost productivity costs. From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled across the nation.

Within the current system, non-traditional community-based addiction treatment services are "carved out" (excluded from coverage) of the MCOs and managed by Magellan, the Behavioral Health Service Administrator (BHSA) contractor for DMAS. For members enrolled in FFS, Magellan covers all traditional and non-traditional addiction treatment services. The non-traditional services include:

- Residential Treatment,
- Opioid Treatment (outpatient counseling with MAT),
- Day Treatment,
- Crisis Intervention,
- Intensive Outpatient Treatment, and
- Case Management.

The "carve out" of the community-based addiction treatment services from MCOs contributed to Virginia's historically fragmented system in which poorly funded community-based addiction treatment services are delivered in distinct siloes separated from traditional mental health and physical health services. Providers who deliver these services have complained that the Medicaid reimbursement rates are lower than the cost of providing care and have struggled to understand who to bill for services. Patients have struggled to understand where to seek services.

Furthermore, the rate structure for addiction treatment services has not been adjusted since 2007 when DMAS first started reimbursing for addiction treatment services. Low reimbursement rates have severely limited the number of providers willing to provide these services to Medicaid and FAMIS members and resulted in inadequate access to treatment. DMAS only spent approximately $2 million on community-based addiction treatment services in State Fiscal Year 2015 and served an average of 734 people per month, demonstrating the underutilization of these services considering the number of Virginians being seen in hospitals/emergency rooms with substance use diagnoses.

If DMAS continues reimbursing at the current low rates for substance use disorder treatment, low utilization of this benefit will continue and it will only be available to limited groups of members (children and pregnant women). If DMAS continues the current benefit package, it will continue to not provide coverage of peer support services for any members and would not cover inpatient and short-term residential detoxification and outpatient substance use disorder treatment for any non-pregnant adult members.

Medicaid, FAMIS and FAMIS MOMS members with diagnoses of substance use disorders (SUD) will continue to experience high rates of hospitalizations and hospital emergency department visits that could be prevented if adequate residential treatment, outpatient treatment, and peer supports were available and accessible.

RECOMMENDATIONS

To address the fragmentation of services and siloes, Virginia sought the authority to fully integrate physical and behavioral health services for individuals with SUD and to expand access to the full array of services for individuals with SUD. DMAS obtained approval from the Governor and General Assembly to "carve in" community-based SUD/ARTS treatment services into managed care plans for members who are already enrolled in MCOs. CMS recommends the use evidence based practice for the treatment of addictive, substance-related conditions as published by the American Society of Addiction Medicine (ASAM).

Since the MCOs already manage all the physical health services as well as the inpatient services, outpatient services, and medications for mental health and substance use, "carving in" the community-based ARTS services will allow the health plans to provide their enrolled members with the full array of all services based on members' levels of need. Magellan will continue to cover these services for those Medicaid members who are enrolled in FFS.

The ARTS waiver was necessary to provide Virginia the authority, and related federal financial participation, to provide coverage of short-term inpatient detox and residential substance use disorder in treatment facilities with greater than 16 beds. This will align Medicaid FFS residential treatment coverage with the CMS Medicaid and CHIP Managed Care Final Rule (CMS-2390-F). The expanded coverage of residential detoxification and residential substance use disorder treatment will be available for all Medicaid enrolled members and will be integrated with the full continuum of addiction treatment services. Seamless care transitions will occur from residential treatment to lower levels of care such as intensive outpatient and outpatient treatment with medications and long-term recovery supports available to all Medicaid enrolled members.

Addiction is a primary, chronic disease of the brain's reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and typically results in disability or premature death.

DMAS recommends the application of the ASAM Criteria which describe a wide range of levels and types of care for addiction and substance-related conditions and establish clinical guidelines for making the most appropriate treatment and placement recommendations for individuals who demonstrate specific signs, symptoms and behaviors of addiction. Application across the Commonwealth of this comprehensive system of multidimensional assessment, broad and flexible continuum of care, interdisciplinary team approach to care, and outcome-driven clinical treatment is expected to substantially reduce the consequences of the current addiction epidemic.

The comprehensive addiction treatment benefit approved previously by the Governor and General Assembly includes the following core components:

- **Expanded coverage of inpatient detoxification and inpatient substance abuse treatment** (ASAM Level 4.0) for all Medicaid members (previously only available to children).

- **Expanded coverage of residential detoxification and residential substance abuse treatment** (ASAM levels 3.1, 3.3, 3.5, and 3.7) for all Medicaid members (previously delivered using outdated, state-defined program rules).

- **Increased rates for existing substance abuse treatment services** currently covered by DMAS by 50% for Case Management and by 400% for Partial Hospitalization (ASAM Level 2.5), Intensive Outpatient (ASAM Level 2.1), and the counseling component (Opioid Treatment) of MAT to align with current industry standards.

- **Added coverage of Peer Supports for individuals with SUD and/or mental health conditions.** Reimbursement will be provided for peers certified by DBHDS who will provide intensive recovery coaching to individuals with SUD at all ASAM Levels of Care and to those who need recovery supports, which will be added to the Medicaid benefit in July 2017.

Major changes under this benefit are illustrated below.

Addiction Treatment Service	Children < 21	Adults*	Pregnant Women
Traditional Services			
Inpatient (ASAM Level 4.0)	X	Added	Added
Outpatient (ASAM Level 1.0)	X	X	X
Treatment using medication – medication component	X	X	X
Non-Traditional Services			
Residential (ASAM Levels 3.1, 3.3, 3.5, and 3.7)	X	Added	50% rate increase
Partial Hospitalization (ASAM Level 2.5)	400% rate increase	400% rate increase	400% rate increase
Intensive Outpatient (ASAM Level 2.1)	400% rate increase	400% rate increase	400% rate increase
Opioid Treatment – counseling component of treatment using medication (ASAM Level 1.0)	400% rate increase	400% rate increase	400% rate increase
Case Management	50% rate increase	50% rate increase	50% rate increase
Peer Recovery Coaching (DBHDS certified peers)	Added**	Added**	Added

X = service was previously covered

Added = service will be covered under the comprehensive addiction treatment benefit passed by the General Assembly starting on April 1, 2017. Rate increases were also included in addiction treatment benefit and will take effect on April 1, 2017.

* Dual eligible individuals have coverage for inpatient and residential treatment services through Medicare.

** Peer recovery support services for adults and family support partners for children and families will be added when DBHDS finalizes the peer certification standards and DMAS is able to ensure that CMS requirements are met for Peer Support Services.

The concept of medical necessity is used throughout DMAS' regulations as the basis for service coverage. Services that are not medically necessary are not covered (not reimbursed) by Medicaid. Because substance use, addictive and mental disorders are biopsychosocial in etiology

and expression, treatment and care management are most effective if they are also biopsychosocial and based on a multidimensional assessment rather than a single diagnosis. DMAS proposes to implement a system that takes into account the biopsychosocial nature of substance use, addiction and mental health disorders to result in a more holistic and evidence-based approach to service delivery and care.

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 disadvantages identified in providing the full continuum of treatment needed to address the substance use crisis and reverse the opioid epidemic in Virginia. The ARTS benefit and waiver are needed to ensure the success of Virginia's delivery system transformation in expanding access to the addiction treatment services that will save lives, improve patient outcomes, and decrease costs. There are no disadvantages to affected providers as their rates of reimbursement are recommended for increase.

The advantages to Medicaid-eligible individuals are discussed above.

Federal demonstration waivers have significant data reporting and evaluation components. CMS will require an independent evaluation of the ARTS waiver to demonstrate any improved outcomes for Medicaid members and cost savings from reducing Emergency Department visits and inpatient hospital utilization. This evaluation will help the Commonwealth demonstrate the impact of the ARTS benefit and waiver on the lives of its citizens, both Medicaid eligible and non-eligible, as well as on the Commonwealth's economy.

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 contained in these recommendations.

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 will be no localities that are more affected than others as these requirements will apply statewide.

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.

This regulatory action is not expected to affect small businesses as it does not impose compliance or reporting requirements, nor deadlines for reporting, nor does it establish performance standards to replace design or operational standards.

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.

Projected cost to the state to implement and enforce the proposed regulation, including: **a) fund source / fund detail; and** **b) a delineation of one-time versus on-going expenditures**	SFY 2017: $2,602,412(GF); $2,602,412(NGF); $5,204,824 Total appropriations SFY 2018: $8,376,259(GF); $8,376,259(NGF); $16,752,518 Total appropriations
Projected cost of the new regulations or changes to existing regulations on localities.	The CSBs/BHAs will incur costs in educating their bachelor degree staff to enable such staff to apply for the CSAC exam/certification.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	Inpatient hospitals, some physicians/nurse practitioners, case managers, residential treatment facilities, group homes, and outpatient clinics
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: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Case management.....152 Emergency Services/Crisis Intervention Service.....96 Managed Withdrawal - Medical Detox.....10 Medical Detox/Chemical Dependency Units.....5 MAT/Opioid Treatment

	Service.....29 MH Crisis Stabilization .....23 MH/SA group home service .....8 Outpatient Managed Withdrawal/Med Detox .....1 Outpatient MH/SA Service.....422 Outpatient SA Service.....9 Partial hospitalization service.....3 Psychiatric Unit service.....28 Psychiatric Unit serv. Children .....10 Residential Treatment SA Women with Child.....3 SA Case Management .....26 SA Half Way House.....3 SA Intensive outpatient services.....99 SA Partial Hospitalization.....9 SA Residential Treatment.....17 SA Supervised Living Service.....28 DMAS does not keep data on how many providers meet the definition of small businesses.
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: a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and 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 will be required to maintain the standard medical record documentation in order to support their claims that are submitted for reimbursement. No additional reporting requirements, record-keeping or administrative costs will be required for these regulatory changes.
Beneficial impact the regulation is designed to produce.	The beneficial impact will be the coverage by Medicaid, for eligible individuals, of addiction and recovery treatment services.

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.

By meeting the CMS requirements, this comprehensive ARTS benefit package allows Virginia to amend the GAP 1115 waiver and apply for a Medicaid 1115 SUD waiver that waives the sixteen (16) bed limit in an Institution for Mental Disease (IMD) including inpatient and residential substance use treatment. This allows DMAS to draw down federal matching funds to support ARTS services delivered to Medicaid-eligible individuals in state psychiatric hospitals, replacing the current State General Fund supporting these services. The waiver would also draw down new federal matching funds that would incentivize providers to expand existing residential detox facilities beyond 16 beds, substantially increasing ARTS capacity. Many community-based providers currently restrict bed capacity to 16 beds specifically so they can bill Medicaid. By allowing community-based residential programs with greater than 16 beds to bill Medicaid, this waiver would substantially increase provider treatment capacity and access to treatment for all Virginians.

Stakeholders and the Governor's Taskforce on Prescription Drug and Heroin Abuse have documented the need for increased reimbursement rates for treatment services to address the prescription opiate and heroin epidemic in the Commonwealth. Opioid overdoses have become the most prevalent type of accidental death in the Commonwealth over the past five years. From 2007 to 2013, nearly 70% of all deaths from drugs/poisons were attributed to opioids. Since 2000, deaths from prescription opioid overdoses have more than doubled. In 2015, 809 Virginians died from prescription opioid and heroin overdoses. . Over the past two years, deaths from heroin overdoses have doubled. Increasing access to addiction treatment through the ARTS benefit and waiver is essential to reverse this epidemic.

Public participation notice

If an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register; and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

Public comment has been positive and helped DMAS to identify key areas for substance use disorder treatment reform beginning in September 2015 until June 2016, using multiple modalities that included the Commonwealth's administrative record, the Virginia Regulatory Town Hall and a variety of electronic and face to face methods all of which were supported by electronic communications provided to interested stakeholders. DMAS held two public hearings on January 5, 2016 in the Richmond area and on January 7, 2016 in the far southwest region in Abingdon, Virginia.

In addition to the web based communication and public hearings, a comprehensive workgroup convened to develop the benefit program structure in collaboration with diverse stakeholders. The SUD/ARTS Workgroup (participant list attached) consisted of managed care organizations, the DMAS Behavioral Health Service Administrator, public and private behavioral health providers, health systems, provider associations, member advocacy organizations, peer support representatives, community service boards, hospital associations, Federally Qualified Health Centers, physician and psychiatric societies as well as staff from the Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Department of Health Professions (DHP), the Virginia Department of Health (VDH) and DMAS. All workgroup activity has been summarized and posted to the DMAS website for review by stakeholders and interested individuals. Information on the workgroup and program design can be found on the DMAS website at: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx.

DMAS posted the draft concept paper on its website and provided notice through the Virginia Regulatory Town Hall on July 1, 2016:
http://townhall.virginia.gov/L/ViewNotice.cfm?gnid=566.

DMAS posted another public notice online through the Commonwealth's administrative record, the Virginia Regulatory Town Hall on July 1, 2016 as well as posted the notice on the DMAS website and distributed through the electronic distribution list. This notice further sought public comments for a 30 day period on the ARTS Waiver "Concept Paper" which incorporated feedback from the earlier public hearings. The ARTS Waiver "Concept Paper" was the draft application to amend the 1115 GAP Waiver. DMAS requested public comments on the entire Addiction and Recovery Treatment Services benefit delivery system design.

All feedback was considered and incorporated as appropriate in the 1115 Waiver amendment which was submitted to the Centers for Medicare and Medicaid Services (CMS) on August 5, 2016.

A summary of public comment and DMAS actions related to those comments is posted online at http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx.

DMAS has not been notified of any concerns from providers, members, or the public.

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 erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents.

The ARTS benefit may strengthen the authority or rights of parents in the education, nurturing and supervision of their children by increasing access to court-mandated addiction treatment that Medicaid-eligible parents may be required to obtain in order to be reunified with children in foster care. Access to addiction treatment may also encourage economic self-sufficiency, self-pride, and assumption of responsibility by individuals with substance use disorders who are able to enter recovery due to the ARTS program.

These changes do not erode the marital commitment. They may strengthen the marital commitment if Medicaid-eligible individuals experiencing strife in their marriage due to a substance use disorder are able to obtain treatment. These changes should not decrease disposable family income

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
	12 VAC 30-130-5000		Creates new ARTS regulations
	12 VAC 30-130-5005		ARTS purpose and authority established.
	12 VAC 30-130-5020		New ARTS definitions.
	12 VAC 30-130-5050		New ARTS eligible individuals established.
	12 VAC 30-130-5100		New ARTS covered services established.
	12 VAC 30-130-5120		New ARTS covered clinic services (OTP); service components, staff requirements, risk management; care coordination; co-occurring enhanced programs.
	12 VAC 30-130-5121		New ARTS covered office-based opioid treatment clinic services

			(OBOT); service components, staff requirements, risk management; care coordination; co-occurring enhanced programs.
	12 VAC 30-130-5140		New ARTS covered practitioner services; service components, staff requirements, co-occurring enhanced programs. (ASAM 0.5)
	12 VAC 30-130-5141		New ARTS covered practitioner services; service components, staff requirements, co-occurring enhanced programs. (ASAM 1.0)
	12 VAC 30-130-5160		New ARTS covered community based intensive outpatient services; service components, staff requirements, co-occurring enhanced programs. (ASAM 2.1)
	12 VAC 30-130-5161		New ARTS covered community based care partial hospitalization services; service components, staff requirements, co-occurring enhanced programs. (ASAM 2.5)
	12 VAC 30-130-5180		New ARTS covered residential group home services; service components, staff requirements, co-occurring enhanced programs. (ASAM 3.1)
	12 VAC 30-130-5200		New ARTS covered residential treatment facility services; service components, staff requirements, co-occurring enhanced programs. (ASAM 3.3)
	12 VAC 30-130-5201		New ARTS covered medium/high intensity residential treatment facility services; service components, staff requirements, co-occurring enhanced programs. (ASAM 3.5)
	12 VAC 30-130-5202		New ARTS covered intensive inpatient residential treatment facility services; service components, staff requirements,

			co-occurring enhanced programs. (ASAM 3.7)
	12 VAC 30-130-5220		New ARTS covered intensive inpatient hospital services; service components, staff requirements, co-occurring enhanced programs. (ASAM 4.0)
	12 VAC 30-130-5500		New ARTS provider requirements; licensing standards.
12 VAC 30-50-100		Inpatient hospital services limits; enrolled providers.	New Incorporation by Reference added to link to new Chapter 130 regulations.
12 VAC 30-50-110		Outpatient hospital services; Federally Qualified Health Centers and Rural Health Clinics	New Incorporation by Reference added to link to new Chapter 130 regulations.
12 VAC 30-50-130		Early and Periodic Screening, Diagnosis and Treatment services	New Incorporation by Reference added to link to new Chapter 130 regulations.
12 VAC 30-50-140		Physician services limits.	New Incorporation by Reference added to link to new Chapter 130 regulations.
12 VAC 30-50-150		Other licensed practitioner services limits.	New Incorporation by Reference added to link to new Chapter 130 regulations.
12 VAC 30-50-180		Clinic services limits.	New Incorporation by Reference added to link to new Chapter 130 regulations.
12 VAC 30-50-228		Community substance abuse treatment services.	REPEALED as it is superseded by new ARTS program.
12 VAC 30-50-491		Case management for AXIS I disorders	Changes update existing text to new ARTS program.
12 VAC 30-50-510		Expanded pre-natal care services.	Residential substance abuse treatment and outpatient substance abuse treatment for pregnant and post-partum women is REPEALED as it is replaced by new ARTS program.
12 VAC 30-60-147		Utilization control: substance abuse treatment.	REPEALED as it is replace with new ARTS program.

12 VAC 30-60-180		Utilization control: substance abuse treatment.	REPEALED as it is replace with new ARTS program.
12 VAC 30-60-185		Utilization control: substance abuse case management	REPEALED as it is replace with new ARTS program.
12 VAC 30-80-32		Reimbursement for substance abuse treatment services.	Establishes reimbursement rules for ARTS services.
12 VAC 30-70-415		Reimbursement for freestanding psychiatric hospitals under EPSDT	Citation to new ARTS regulations added.
12 VAC 30-70-417		Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT	Citation to new ARTS regulations added.
12 VAC 30-130-540 thru -130-590		Community Mental Health Mental Retardation Services substance abuse treatment services.	REPEALED as it is replaced with new ARTS program.

ARTS WORKGROUP

Virginia Premier
Aetna Better Health
Anthem HealthKeepers Plus
Humana
Optima Family Care
Virginia Association of Health Plans
INTotal Health
Magellan of Virginia
Beacon Health Options
Richmond Behavioral Health Authority
Cumberland Mountain Community Services Board
Phoenix Houses of the Mid Atlantic
Caliber Virginia
Northwestern Community Services Board
Virginia Community Healthcare Association
Virginia Association of Community Services Boards
Community Care Network of Virginia IT Infrastructure Partnership
VOCAL
National Alliance for Mental Illness - Virginia

Department of Behavioral Health and Developmental Services
Virginia Department of Health
Department of Health Professions
Virginia Commonwealth University
Department of Medical Assistance Services

If you have any questions or need any additional information, please feel free to call me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General

REGULATION REVIEW

Date: November 30, 2016

Department: DMAS

VAC #: 12 VAC 30-130-5000 et seq, 30-50-100, 30-50-110, 30-50-130, 30-50-140, 30-50-150, 30-50-180, 30-50-491, 30-50-510, 30-60-181, 30-60-185, 30-70-201, 30-70-415, 30-70-417, 30-80-32.

Purpose and synopsis of the regulation(s), including any relevant changes:

The purpose of the proposed regulation is to create a new program, Addiction and Recovery Treatment Services (ARTS), which would provide a comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Does the regulation conflict with the United States or Virginia Constitution?
No

Does the regulation conflict with federal or state law or regulation?
No

Have you reviewed public comment?

Public comment has not been received.

Are there any media or politically sensitive issues that should be called to the Chief's attention?
No

Attach a copy of the background document, proposed regulation, draft letter of assurance, and public comments (if any).

Approval:

Section Chief _____ ***Date*** _____