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Final Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12VAC 30-50, 60, and 130
Regulation title	Amount, Duration, and Scope of Services; Methods and Standards to Assure High Quality of Services
Action title	Community Mental Health and Substance Abuse Treatment Services
Document preparation date	09/25/2003

This information is required for executive review (www.townhall.state.va.us/dpbpages/apaintro.htm#execreview) and the Virginia Registrar of Regulations (legis.state.va.us/codecomm/register/regindex.htm), pursuant to the Virginia Administrative Process Act (www.townhall.state.va.us/dpbpages/dpb_apa.htm), Executive Orders 21 (2002) and 58 (1999) (www.governor.state.va.us/Press_Policy/Executive_Orders/EOHome.html), and the *Virginia Register Form, Style, and Procedure Manual* (http://legis.state.va.us/codecomm/register/download/styl8_95.rtf).

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

The suggested final regulations will improve the delivery of community mental health and substance abuse treatment for pregnant and postpartum women and remove unnecessary regulatory requirements. The changes are the result of a workgroup that included public and private providers, state agency representatives, and consumers. The more significant changes that were contained in the previously proposed regulations were: remove requirements that providers make services available 24-hours per day and accept all patients regardless of their ability to pay; remove the requirement that case management services be coupled with mental health support services; add needed minimum staff qualifications; remove requirement for a history of hospitalizations from the service eligibility criteria; clarify that mental heath support services may be rendered in order to maintain recipients in their communities; revise services definitions; clarify/revise provider qualifications; modify annual service limits as appropriate; and modify provider licensing requirements as appropriate.

The additional significant changes in the final adopted regulations are: changing language from "assistive" to "assertive" community treatment, allowing providers of Mental Health Support Services to also be licensed as Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) providers, including case management activities as part of ICT, correcting the billing units for Mental Health Support services to 1 to 2.99 hours, changing language from chemical addiction to substance use disorder for ICT services, redefining the place of service for ICT, and changing language from addiction to substance abuse for Substance Abuse Treatment services for pregnant women.

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 with the attached amended State Plan pages Community Mental Health and Substance Abuse Treatment Services (12 VAC 30-50, 30-60, and 30-130) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

__10/6/2003_____________ __/s/ P. W. Finnerty________________

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal source of legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly bill and chapter numbers, if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, §32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code also provides, in the Administrative Process Act (APA) §§2.2-4007 and 2.2-4013, for this agency's promulgation of proposed regulations subject to the Governor's review.

Pursuant to the regulatory review requirements of Executive Order 21(02), Periodic Review of Existing Regulations, DMAS, in collaboration with DMHMRSAS, reviewed its controlling

regulations for its community mental health services. A number of issues were identified in discussions with a dedicated work group comprised of state agency staff, providers, and affected consumers.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.

The regulations for the community mental health and substance abuse treatment services have not been revised since 1997. Several issues have been identified that need revision, such as duplicative language, impracticable and unnecessary requirements for service provision. Both participating providers and consumers have requested these revisions. These proposed changes are expected to protect the health and welfare of the citizens by easing access to these services. These changes will also benefit the service providers by removing administrative barriers to the rendering of these services.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The sections of the State Plan for Medical Assistance that are affected by this proposed regulatory action are: the Amount, Duration, and Scope of Services (Attachment 3.1 A&B, Supplement 1 (12 VAC 30-50-130, 50-226)) and Case Management for Services (Attachment 3.1 A&B, Supplement 2 (12 VAC 30-50-420-, 50-430, 50-510)); Methods and Standards to Assure High Quality of Care (Attachment 3.1-C (12 VAC 30-60-61, 60-143, 60-147)); as well as state only regulations (12 VAC 30-130-550, 130-565, 130-570).

The following changes are being promulgated to revise the current regulations. These regulation revisions are needed to improve the services delivered to recipients and to improve clarity for service providers:

> References to DMHMRSAS licensing requirements are being removed as they are duplicative, occurring twice in the services and provider qualification regulations;
>
> References to twenty-four hour response capability for providers are being removed from 12 VAC 30-130-570 and 12 VAC 30-130-565 as this requirement unduly restricts providers to only public providers and prohibits private providers from rendering the same service;

References to the requirement for serving individuals, regardless of ability to pay, are being removed from 12 VAC 30-130-570 as this can also have the effect of limiting participation of providers to only public providers;

References to who can perform an evaluation and assessment for substance abuse services are being moved from 12 VAC 30-130-570 to 12 VAC 30-130-565 as it is currently misplaced; and

References regarding mental retardation are being removed from 12 VAC 30-130-570. In 2000, CMS required that all mental retardation services be moved to the mental retardation waiver program rather than State Plan covered services. Removal of this reference was overlooked when the other changes were made.

Individual services are revised as follows (input was obtained from the DMAS sponsored workgroup):

1. Case Management:

- Eliminating the requirement that case management services and mental health support services must be provided concurrently.

- Eliminating the limitations regarding who can provide case management services for Mental Health Support Services.

2. Mental Health Support Services:

- Adding the minimum staff qualifications regarding who may deliver mental health support services; a Qualified Mental Health Professional (QMHP) may perform the assessment, sign the Individual Service Plan (ISP), and supervise the care, a paraprofessional may also deliver the service.

- Removing the requirement for "a history of hospitalization" from the service eligibility criteria;

- Changing the monthly limitation of 31 units (1 unit = 1 to 3 hours) to a yearly limit of 372 units to allow for more intense initial service delivery; and

- Adding language clarifying that MH Support Services may be delivered to maintain the recipient in the community.

3. Day Treatment/Partial Hospitalization:

- Adding language clarifying that it can be delivered to maintain the recipient in the community; and

- Revising the service definition.

4. Psychosocial Rehabilitation:

  - Removing "for adults" from the service title; and
  - Adding review requirements for certain services, requiring services review by a licensed mental health professional at specified intervals to insure review of appropriate services.

5. Crisis Intervention Services: Adding pre-screeners and QMHPs as providers.

6. Intensive Community Treatment: Clarifying why services in the clinic-setting must be documented.

7. Intensive In Home:

  - Adding clarifying language regarding which services may be rendered in the community;
  - Adding the statement "services are directed toward the treatment of the eligible child" to 12 VAC 30-50-130;
  - Changing the minimum requirement from 5 hours of service per week to 3 hours per week and requiring documentation of the need for more intensive services when provided in outpatient clinics;
  - Removing the specifications for caseload size and requiring sufficient staff to be available to meet the identified needs of the child; and
  - Adding to 12 VAC 30-60-61 that the Intensive In-Home services provider be licensed by DMHMRSAS as an Intensive In-Home provider.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.

If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

The proposed regulations are intended to keep consumers in the community thereby avoiding more expensive hospitalizations. The advantage of these proposed regulations is improvement in the ease of delivering services. Unnecessary regulations are being removed. It is anticipated that provider efficiency will improve with reducing regulatory requirements. There are no anticipated disadvantages to the public or the Commonwealth.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

Section number	Requirement in proposed regulation	Proposed change in final regulation and rationale
30-50-226	Case Management activities are not included as a billable service	*Case management activities will be reimbursable activities as they are an integral part of ICT.*
30-50-226	Current language for ICT is "individuals who will not or cannot be served in the clinic setting" in the eligibility criteria for ICT	*DMAS will change the language to "individuals who are best served in the community" to more accurately reflect current practice.*
30-50-226	The billing unit for Mental Health Support services was incorrectly listed as one hour	*The billing unit will be corrected to remain as it is currently, one to less than three hours.*
30-50-226	Language is currently "chemical addiction"	*DMAS agrees that changing the language to substance abuse disorder more accurately reflects current practice.*
30-50-510	Language currently refers to "addiction"	*DMAS agrees that changing the language to substance abuse more accurately reflects the required knowledge base.*
30-60-143	Language incorrectly refers to "assistive"	*Language will be corrected to refer to "assertive"*
30-60-143	Language currently only allows providers licensed as Supportive In-Home providers to render the service	*Language will be amended to allow providers licensed as providers of Intensive Community Treatment (ICT) and Programs of Assertive Community Treatment (PACT) to be eligible to render the service. This reflects current practice in the community.*

Public comment

Please summarize all comment received during the public comment period following the publication of the proposed stage, and provide the agency response. If no public comment was received, please so indicate.

DMAS' proposed regulations were published in the June 16, 2003 *Virginia Register* (VR 19:20, p 2931) for their comment period from June 16 through August 15, 2003. Comments were received from representatives of the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Medicaid subcommittee of the Virginia Community Services Board (VACSB) Regulatory Committee, and one individual via electronic mail and letters.

Comment: The comments from the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) concerned several topics:

The commenter asked that the regulations be amended to reflect the correct terminology as the licensing standard for providers of Intensive Community Treatment services. The commenter understood that it was DMAS' intention to reference the DMHMRSAS' licensing categories of Intensive Community Treatment (ICT) and Programs of Assertive Community Treatment (PACT).

The commenter stated that "assertive community treatment is an intensive approach to the treatment of people with serious mental illnesses that relies on the provision of a comprehensive array of services in the community". The commenter added that the PACT model originated in the late 1970s in Madison, Wisconsin, and referenced a U.S. Surgeon General report that endorsed this service model.

This commenter stated that modifying the DMAS' ICT regulations to more closely conform with the DMHMRSAS licensing standards would improve that agency's ability to meet Virginia's Olmstead mandate and the General Assembly's directive to reduce hospitalizations by initiating PACT statewide. The commenter provided several statistics to attest to the efficacy of the PACT service model.

The commenter made several specific suggestions:

VAC Section	Comment	*Agency response*
12 VAC 30-50-226	Case management activities should be an integral part of the service	*DMAS agrees and will amend the regulations to include case management activities as a part of ICT.*
12 VAC 30-50-226	Redefine the term "individuals who will not or cannot be served in the clinic setting" in the eligibility criteria for ICT	*DMAS agrees and will change "individuals who will not or cannot be served in the clinic setting" to "individuals who are best served in the community".*
12 VAC 30-60-143	Amend the provider qualifications for Mental Health Support Services and Case Management Services to include those providers licensed by DMHMRSAS to provide ICT or PACT.	*DMAS agrees and will amend the provider qualifications for Mental Health Support Services to include those providers licensed by DMHMRSAS to provide ICT or PACT. Because case management activities are not included as part of Mental Health Support Services, licensure as a case management provider will not be added.*
General Comment	Work further with DMHMRSAS to develop new DMAS regulations for a	*The intent of this regulatory action is to revise the current Community Mental Health*

	Medicaid service that matches that agency's ICT and PACT licensing regulations.	*services. Therefore, any action that would significantly change the current services would have to be authorized by CMS and cost projections made. DMAS is receptive to working with DMHMRSAS to evaluate the feasibility of adding new services that are more consistent with the DMHMRSAS regulations.*
12 VAC 30-50-226	Terminology should be revised to indicate that the individual have a history of "co-occurring serious mental illness and substance use disorder" instead of a history of serious mental illness and chemical addiction". The commenter felt that the precise meaning of the term 'addiction' was too strict a standard to apply to the mentally ill individuals who should receive this service.	*DMAS agrees and will amend the regulations (12 VAC 30-50-226) to state "co-occurring serious mental illness and substance abuse disorder" instead of the proposed regulations language of 'a history of serious mental illness and chemical addiction'.*
12 VAC 30-60-143	Terminology should be expanded to include additional DMHMRSAS' licenses that providers of mental health support services are required to hold in order to be eligible for Medicaid reimbursement. These providers should be able to have either licenses for psychosocial rehabilitation services or mental health community support services as well as the supportive in-home services contained in the proposed regulations.	*DMAS disagrees with the recommendation to allow Mental Health Support Services providers to be licensed as psychosocial rehabilitation services or mental health community support services. Current DMAS regulations require psychosocial rehabilitation services to be program focused and delivered in a program setting, rather than the home or community. DMAS prefers to defer allowing licensure as a provider of mental health community support services until the service is developed and providers are licensed as such.*

12 VAC 30-60-143	Terminology that prohibits Medicaid coverage of any services that are 'strictly vocational' in nature should be expanded to elaborate on the definition of 'strictly vocational'. The comments suggested that 'strictly vocational' be expounded to state that such services include, but are not limited to, vocational rehabilitation services that are otherwise available to the individual through a program funded under § 110 of the Rehabilitation Act of 1973. These services include, but would not be limited to, such basic education programs as instruction in reading, science, mathematics, or GED. The commenter felt that such clarification would assist providers and policy makers to distinguish between employment services funded under the Rehabilitative Services Act and mental health rehabilitative services provided to assist consumers in achieving recovery and community integration through employment.	*DMAS agrees to clarify the meaning in the Community Mental Health Rehabilitative Services Manual of "strictly vocational". The Code of Federal Regulations is more inclusive than just services that are covered under the Rehabilitation Act of 1973. Medicaid is only allowed, by the federal funding agency, to make payments for medical services and is specifically prohibited from reimbursing for services related to the preparation of individuals for paid or unpaid employment. To attempt to reimburse for such services would risk the loss of the substantial federal matching dollars drawn down by the Commonwealth for these services.*

Comment: The Medicaid subcommittee of the VACSB summarized comments that were submitted by 19 community services boards across the Commonwealth. The comments discussed an issue of overall concern: the DMAS requirement that an LMHP (Licensed Mental Health Professional) provide oversight and documentation requirements would have a greater than expected impact. "The system-wide loss of revenue particularly in areas staffed by licensed staff make this an even more costly resource to use. We hope that the proposed alternatives will be seriously considered, as there are very real concerns about meeting this largely administrative requirement while also insuring *[sic]* enough resources for direct service provision to meet consumer needs." Additional, more specific comments from this organization are set out below:

VAC Section Proposed Change	Comment/Reason	*Agency Response*
30-50-226, 5c. (Mental Health Support) Billing is by unit (one unit is one hour but less than three hours)	There is an understanding that making one billing unit equivalent to one hour was an unintended change. However, the consequence of this type of change was of concern to many due to the uncertainties that still exist in transitioning away from time range unit billing and its impact on billing, service provision, etc. The proposed change reflects the wording in the current manual. Recommend reconsidering the current disallowance for staff travel time to and from various locations in the performance of their duties.	*DMAS acknowledges that the reference to changing billing to one unit equaling one hour is an error, the unit of service will be equal to one hour but less than three hours per encounter, per the current regulations.*
30-50-226 Intensive In-Home Case management is not an additional covered service.	The restriction on billing for case management services while the youth is receiving this service has resulted in poor coordination and transition between service levels. A locality's private providers are not providing the required 24-hour service but are referring clients back to the CSB in an emergency.	*Case management activities are required as a part of this service. Federal regulations do not permit duplication of services, therefore, case management cannot be billed separately.*
30-50-226 ICT Service Service definition is based on client's willingness.	Should be re-defined from client's willingness or ability to come to the office for services to the 'necessity of the service to be provided out of the office at least 75% of the time'.	*DMAS agrees to language changes to define ICT services as one that is best delivered in the community.*

30-60-143, H1 (Mental Health Support) The assessment must be completed by a LMHP or QMHP who is not involved in the direct provision or supervision of the service.	The proposed requirement for approval of the initial authorization by a LMHP is a concern to many due to resource unavailability, the potential additional expense balanced with meeting consumer direct service needs, and the lack of LMHP involvement or familiarity with the service. The proposed change would provide assurance that the assessment is an objective evaluation of the need for the service by a mental health professional who is not directly involved in the provision of the service, but would not lock the provider into using a higher cost resource.	*For Mental Health Support Services, the requirement is for a licensed mental health professional (LMHP) to review and sign the assessment. The LMHP is not required to perform the assessment. There is no requirement for the reviewer to not be directly involved with the care of the client as the comment states. DMAS supports this requirement as one method to insure quality care. The requirement for a review every six months is a request from advocates and consumers in the workgroup. It is felt that a review will assist in monitoring progress toward recovery goals. Again, there is no requirement that the reviewer not be involved in the care. DMAS supports the requirement for the review of the appropriateness of the delivered services. The removal of the requirement for concurrent billing of case management and mental health support services was removed to eliminate unnecessary services. Workgroup members felt that many consumers only needed MH support services and that requiring case management was duplicative. Private providers have also had difficulties rendering needed services if the consumer was not able to access case management services.*
30-60-143	Not clear what constitutes QMHP supervision.	*This will be clarified in the Community Mental Health Rehabilitative Services Manual.*
30-60-143, H9 (Mental Health Support) Service, which continue for six consecutive months, must be reviewed at the end of the six month period of authori-zation by a LHMP or QMHP who is not involved in the	The proposed requirement for 6 month re-authorizations to be done by LMHP is of concern to many due to resource unavailability, the potential additional expense balanced with meeting consumer direct service needs, the lack of LMHP involvement or familiarity with service, and the fact that current	*For Mental Health Support Services, the requirement is for a licensed mental health professional (LMHP) to review and sign the assessment. The LMHP is not required to perform the assessment. There is no requirement for the reviewer to not be directly involved with the care of the client as the comment states. DMAS supports this requirement as one method to insure quality care. The requirement for a review every six months is a request from advocates and consumers in the workgroup. It is felt that a review will assist in monitoring progress*

direct provision or supervision of the service	system of reauthorization by QMHP is working. The proposed change would provide assurance that the re-authorizations are an objective evaluation of the need for the service by a mental health professional who is not directly involved in the provision of the service, but would not lock the provider into using a higher cost resource.	*toward recovery goals. Again, there is no requirement that the reviewer not be involved in the care. DMAS supports the requirement for the review of the appropriateness of the delivered services.*
30-60-143, H	The removal of the requirement for case management as a companion or prerequisite for this service was cited by several respondents due to concern over how this would impact the service operationally since it does not have an indirect service component which has been the role of the case manager. There may be the potential for more disconnected services for the consumer. Adding the requirement for initial assessment and the 6-month reauthorization to be completed by someone not directly involved in service provision, supports the involvement of a case management type component in the service provision.	*The workgroup decided that it would improve access to care to allow a client to receive only Mental Health Support Services if that was all that is needed. The client may also receive case management services, if indicated. There is no requirement that the provider reviewing the assessment not be directly involved in the care.*
30-60-143 Program of assistive community treatment	Should be changed to assertive community treatment.	*DMAS agrees to language changes to define ICT services as one that is best delivered in the community. The correction to assertive rather than assistive will be made.*

30-60-143 Crisis intervention and Crisis stabilization	Services are distinct but have similar criteria of eligibility and purpose of outcome but different protocol requirements. Services should either be integrated, merged into one or should be better specified, differentiated.	*Revisions to these services were considered in the workgroup but due to budget constraints, changes cannot be made at this time.*
30-60-143 Case management	Recommend change to active case management; seems to be a conflict of interest in allowing the same service professional to perform multiple roles; would the proposed changes pose problems to private providers in marketing their services to potential clients; discon-tinuing coverage of case management services 30 days prior to hospital discharge is problematical as considerable case management work occurs at this time to prepare the client and community for the client's re-entry.	*The removal of the requirement for concurrent billing of case management and mental health support services was removed to eliminate unnecessary services. Workgroup members felt that many consumers only needed case management services and that this requirement was duplicative. Private providers have also had difficulties rendering needed services if the consumer was not able to access case management services. The change that deletes the prohibition against a service provider performing case management was lifted per recommendations of the workgroup. Agencies may continue to enforce the restriction if desired. The case management provider is not required to discontinue case management services one month prior to hospitalization.*
30-50-510 SA Residential/Day Treatment for Preg-nant Women	Strongly endorsed changing the service limits on this service and eliminating the once per lifetime admission restriction. Term 'chemical addition' needs to be updated to 'substance abuse' as it is the more current term, is less restrictive as it does not require a diagnosis of dependence and better describes the intended population.	*For Substance Abuse Services for pregnant women, the change will be made to use the term substance abuse. Clarification about supervision will be included in the manual. There is no requirement to discontinue case management activities thirty days prior to hospitalization, and there can be no billable contacts while the consumer is in an IMD.*

<u>Comment:</u> One individual commenter stated that case management activities should be included under the Intensive Community Treatment service. This commenter also stated that DMAS should reinterpret the language for eligibility to refer to the service not the individual. This commenter believed that these changes would encourage assertive community treatment for the most severe adults with mental illness.

<u>Agency Response:</u>
DMAS agrees to these comments, please see Agency Response above.

All changes made in this regulatory action

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail new provisions and/or all changes to existing sections.

VAC Section	Proposed Change	Reason
12 VAC 30-50-130	Editorial change.	
12 VAC 30-50-226	Revised definitions; service descriptions and recipient criteria are added; service limits added.	
12 VAC 30-50-420	Case management provider qualifications modified/ expanded; provider staff knowledge/skills/abilities moved; removed 24-hour access; removed provision of services to all patients regardless of ability to pay/Medicaid eligibility; service limit/ restriction removed.	
12 VAC 30-50-430	Case management provider qualifications modified/ expanded; provider staff knowledge/skills/abilities moved; removed requirement for 24-hour access; removed provision of services to all patients regardless of ability to pay or their Medicaid	

	eligibility; service limit/ restriction removed.	
12 VAC 30-50-510	Service limit changed; lifetime limit removed; recipient criteria set out; provider qualifications set out.	
12 VAC 30-60-61	Provider standards set out; billing unit language removed; caseload standards removed.	
12 VAC 30-60-143	General provider standards set out; removed linkage to state regulations that are being repealed; required level of provider professional licensing set out; patient criteria removed; standards set out for mental health support services.	
12 VAC 30-60-147	Editorial changes.	
12 VAC 30-130-550	Text repealed as no longer needed.	
12 VAC 30-130-565	Allows women who used substances within 6 weeks of incarceration to be eligible for the service.	
12 VAC 30-130-570	Text repealed as no longer needed.	

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability.

The proposed regulations will support keeping individuals in their homes and communities, thus keeping them with their families. The proposed regulations will assist in helping individuals in their recovery and promote stability. These improvements to these existing regulations are

expected to strengthen parental authority and rights; encourage self-sufficiency, self-pride and may enhance individuals' assumption of responsibility for themselves, their spouses, and their children. It is not expected to affect disposable family income.