Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-50-130; 12VAC 30-50-226; 12 VAC 30-60-5; 12VAC 30-60-61; 12 VAC 30-60-143; 12VAC 30-130-2000; and 12 VAC 30-130-3000 et seq.
Regulation title	Amount, Duration and Scope of Medical and Remedial Services; and Standards Established and Methods Used to Assure High Quality of Care; Marketing Requirements and Restrictions (new); Independent Clinical Assessment Requirements for Behavioral Health Services
Action title	2011 Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (no more than 2 short 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

The agency is proposing this regulatory action to comply with Chapter 890, Item 297 YY, of the *2011 Acts of the Assembly* that gives DMAS authority to make programmatic changes in the provision of Community Mental Health Rehabilitative Services (specifically Intensive In-Home services and Community Mental Health Support services) in order to ensure appropriate utilization, cost efficiency and provider qualifications appropriate to render these Medicaid covered services. This action includes: (i) changes to provider qualifications including meeting licensing standards; (ii) marketing requirements/restrictions; (iii) new Independent Clinical Assessment (ICA) requirements, and; (iv) language enhancements for utilization review requirements to help providers avoid

payment retractions. These changes are part of a review of the services to ensure that they are appropriately utilized for individuals who meet the medical necessity criteria. New ICAs, conducted by local community services boards or behavioral health authorities (CSBs/BHAs), are being required prior to the onset of specified services until DMAS' Behavioral Health Services Administrator contractor can assume this responsibility. Providers that are permitted to claim Medicaid reimbursement for specific services are specified by license type.

The changes being made in this final stage are: (i) terminology changes, for example, service-specific provider assessments is changed to service-specific provider intakes in response to issues raised during an audit by the federal Office of the Inspector General; (ii) additional provider types are being permitted to render services, for example, in addition to Licensed Mental Health Professionals (LMHPs), LMHP-supervisees and LMHP-residents are added; (iii) full-time equivalency of part-time work experience is being added in response to public comment; (iv) provision is made for different professional employees of the same provider to use electronic health records; (v) provision is made that the provider secure written permission from the individual before communicating with the individual's primary care provider concerning the receipt of community mental health services; (vi) DBHDS licenses that certain providers are required to secure prior to becoming a Medicaid provider and rendering services are correctly identified in response to public comment; (vii) intensive community treatment services being limited to adults has been removed in response to a directive from the Centers for Medicare and Medicaid Services (CMS), and; (viii) definitions have been adjusted to accommodate public comments.

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 or board 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 and regulations 2011 Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications (12 VAC 30-50-130; 12VAC 30-50-226; 12 VAC 30-60-5; 12VAC 30-60-61; 12 VAC 30-60-143; 12VAC 30-130-2000; 12 VAC 30-130-3000; 12 VAC 30-130-3010; 12 VAC 30-130-3020; and 12 VAC 30-130-3030) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

Date

Cynthia B. Jones, Director

Dept. of Medical Assistance Services

Legal basis

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

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, §§ 32.1-324 and 325, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The agency is proposing this regulatory action to comply with Chapter 806, Item 307 LL, of the 2013 *Acts of Assembly* that gives DMAS authority to make programmatic changes in the provision of Intensive In-Home (IIH) services and Community Mental Health services (CMHS) in order to ensure appropriate utilization, cost efficiency, and improved provider qualifications. In recent years, the utilization of certain community-based mental health services has substantially increased. These changes are part of an agency review of the services being rendered and reimbursed to ensure that they are appropriately utilized and medically necessary. Specifically, the referenced section of the 2013 *Acts of Assembly* states:

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

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

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

"(b) Assesses the quality of those services;

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

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

The 2013 *Acts of Assembly* also authorized the Department of Medical Assistance Services (DMAS) to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization (Item 307, RR(e)). The overall goals of this care coordination model are twofold: 1) improve the coordination of care for individuals, who are receiving behavioral health services, with acute and primary services; and 2) improve the value of behavioral health services purchased by the Commonwealth without compromising access to these services for vulnerable populations. Pursuant to this directive, DMAS solicited proposals for a Behavioral Health Services Administrator (BHSA) for members enrolled in Virginia's Medicaid/FAMIS Plus/FAMIS programs who are receiving behavioral health services not currently provided through a managed care organization but through the fee for service system. The selected BHSA will only provide administrative services including, but not limited to, care coordination activities, authorizing, monitoring, and encouraging appropriate behavioral health service utilization. Implementation of the new care coordination model is expected to occur in December 2013.

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

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons it 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.

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

promote improved quality of Medicaid-covered behavioral health services provided to individuals.

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

Substance

Please 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 regulations affected by this action are the Amount, Duration and Scope of Services (12 VAC 30-50-130 (skilled nursing facility services, EPSDT, and family planning) and 12 VAC 30-50-226 (community mental health services for children and adults); Standards Established and Methods Used to Assure High Quality of Care (12 VAC 30-60-5 (general utilization review requirements applicable to all Medicaid covered services; 12 VAC 30-60-61 (utilization review of services related to the EPSDT program) and 12 VAC 30-60-143 (community mental health services for children and adults and mental health services utilization)). New regulations entitled Marketing Requirements and Restrictions (12 VAC 30-130-2000) and Behavioral Health Services (12 VAC 30-130-3000 et seq) are recommended.

DMAS has covered certain residential and community mental health services (including Intensive In-Home services to children and adolescents under age 21, Therapeutic Day Treatment, Level A Community-Based Services for Children and Adolescents under 21, Therapeutic Behavioral Services (Level B), Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, Crisis Intervention, Intensive Community Treatment, Crisis Stabilization, and Mental Health Support Services) for a number of years. These services are non-traditional mental health services and are typically only covered by Medicaid. These services are provided only to children and adolescents under the authority of 42 CFR § 440.40.

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

Some of the growth in service usage has been due to more community-based services being provided. Some of the growth in usage is attributed to the provision of services to individuals who do not meet the medical necessity criteria. The proposed changes included in this package are intended to improve the quality of rendered services, by requiring that providers meet specified licensing and qualification standards in order to be paid by Medicaid. The changes also address appropriate medical necessity criteria so that the young people who truly need these services receive it but those who do not need it, don't receive it.

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

These affected sections also set forth rules and penalties related to the marketing of Medicaid mental health services. (see 12 VAC 30-130-2000 Part VII.) These limitations are recommended to address issues of providers 'selling' their services to families.

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

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

Section 12 VAC 30-50-130 B contains the Medicaid requirements for the coverage of services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Pursuant to 42 CFR §§ 440.40(b) and 441.50 *et seq*., these controlling federal regulations set out the requirements for this program of well-child preventive health services for Medicaid individuals from birth through the age of 21 years. In 1989, in the context of the federal *Omnibus Budget Reconciliation Act of 1989* (§ 6403), Congress established that Medicaid programs were required to provide all medically necessary services, identified as needed as a result of an EPSDT screening, without regard to whether

or not the needed services were otherwise covered under that state's State Plan for Medical Assistance. Services provided under the authority of this regulation can only be covered for children.

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

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

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

Section 12 VAC 30-50-226 provides for Community Mental Health Services, including day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization, and mental health support services. These services are covered for both children/adolescents and adults. DMAS is specifying, in this recommended final action the types of licensed professionals, consistent with DBHDS' licensing standards, who will be permitted to render these services for purposes of claiming Medicaid reimbursement. The Definition section is expanded to provide for terms used in this section, such as Individual Service Plan and service authorization. This section requires that service-specific provider intakes (as defined in 12 VAC 30-50-130) be prepared to document how the individual to be treated meets the criteria for this service. Absent such documentation, DMAS cannot determine if the rendered services were appropriate for the individual's diagnosed medical needs and therefore retracts payments to providers. References to case management are changed to care coordination, as part of the Intensive Community Treatment package of services, in response to comments from CMS. A few non-substantive, technical edits are proposed for purposes of regulatory parallel construction across subsections.

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

Section 12 VAC 30-60-61 provides the utilization review requirements for EPSDT services (as set out in 12 VAC 30-50-130) which must be met by providers in order to claim

reimbursement from Medicaid. These proposed changes require: (i) provider documentation and supervision requirements are enhanced; (ii) completion of an individual service plan within a specified time period; (iii) individual-specific provider progress notes; (iv) provider licensure by DBHDS; (v) provider enrollment with DMAS; (vi) maintaining currency of the individual service plan; (vii) provider compliance with DMAS' marketing requirements, and; (viii) provider collaboration with the individual's primary care provider. A new Definition subsection is created.

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

Providers of Therapeutic Day Treatment (TDT) services will be required to be licensed by DBHDS as well as be enrolled with DMAS. TDT providers must prepare service-specific provider intakes, before the onset of services, which must also be appropriately reviewed and signed/dated. This final stage requires documented coordination with providers of case management services. Providers are required to adhere to DMAS' marketing requirements set out in 12 VAC 30-130-2000 for the purpose of receiving Medicaid reimbursement for services rendered. Provision is made for how lapses in services are to be handled.

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

Providers of Level B residential treatment services, called Therapeutic Behavioral Services for Children and Adolescents, must be licensed by DBHDS. Service authorization is required for all Level B services before the services will be reimbursed. Service-specific provider intakes and Individual Service Plans must be developed, appropriately reviewed, signed/dated, and must be kept up to date as the individual's condition changes

over time. Services which have been based upon incomplete, missing or outdated intakes or Individual Service Plans shall be denied reimbursement. Coordination with case managers and primary care providers is also required.

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

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

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

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

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

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

During the time period covered by the proposed stage regulations' development and public comment, the federal Office of the Inspector General (OIG) also reviewed DMAS' behavioral health program policies. This Office's review and comments concerned the perceived duplication between DMAS' Independent Clinical Assessment requirements and providers' service-specific assessment. DMAS does not agree with this interpretation and has, therefore, created distinctions, in this final stage, between these two required elements.

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.

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

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

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 at proposed stage	What has changed	Rationale for change
12 VAC 30-50-130 Definitions	'Certified pre-screener' defined as an employee of either DMAS, the BHSA, or a local CSB/BHA.	Reference to DMAS/BHSA has been removed.	Such persons cannot be employees of DMAS/ BHSA.
	'Clinical experience' only referred to full time experience.	Part-time equivalency to full time experience is added.	Response to public comment. DBHDS' guidance document has been incorporated by reference.
	'Human services field' referred to specific relevant fields of professional endeavors.	Definition uses the same definition as already established by DBHDS.	Clarification to refer to the definitions published by the appropriate licensing agency.
	Referred only to LMHP, QMHP-C.	Reference is added to LMHP-supervisees and LMHP-residents. Reference is added to QMHP-eligibles.	To increase provider availability in order to avoid access to care problems.
	Referred to service-specific provider 'assessment'.	Changed 'assessment' to 'intake'.	To clarify the differences between two similar steps for the OIG.
		Added definition of psychoeducational activities.	Clarification
12 VAC 30-50-130 B.5.b.	Mental health services covered under EPSDT specified the type of professionally licensed person who could render the service for Medicaid reimbursement.	The list of professionally licensed persons who can render these covered services for purposes of Medicaid reimbursement has expanded to include supervisees, residents and eligibles. Necessary to quantify or explain the meaning of IIH services being rendered 'not solely' in the individual's residence as the issue has come up in appeals.	To increase provider availability in order to avoid access to care problems. DMAS has removed 'not solely' and is providing that the settings of interventions be provided for in the Individual Service Plan.

12 VAC 30-50-226 Definitions	Clinical experience referred only to full time work experience as meeting DMAS' standard.	Definition expanded to include equivalent part-time hours as meeting the DMAS' standard. Definition of Individual Service Plan is modified to permit the adult individual's participation in the ISP's development. When the individual is a minor child, then parent/legal guardian signature on ISP is also provided.	Specific response to numerous public comments received. Reference to DBHDS guidance document containing a definition has been added. Clarification
12 VAC 30-50-226 B	Mental health services covered under the authority of 42 CFR 440-130(d) in the community specified the type of professionally licensed person who could render the service for Medicaid reimbursement. Providers of crisis intervention/stabilization are required to register the individual with DMAS or the BHSA contractor to avoid duplication of services and ensure informed care coordination.	The list of professionally licensed persons who can render these covered services for purposes of Medicaid reimbursement has expanded to include supervisees, residents and eligibles. Time limit of one business day is added for the registration.	To increase provider availability in order to avoid access to care problems. To ensure timely communication from providers concerning the individuals being treated for crisis situations.
12 VAC 30-60-5 F	Sets out new general utilization review requirements specific to community mental health services.	Added reference to national standardized medical necessity criteria, like McKesson InterQual Criteria, as required for Medicaid coverage of these community mental health services.	Medical necessity criteria were provided in the proposed stage text for 12 VAC 30-50-130 and -50-226. Including this reference here in the final stage addresses a drafting oversight in the previous proposed stage.
12 VAC 30-60-61	Mental health services covered under EPSDT specified the type of professionally licensed person who could render the service for Medicaid reimbursement. No reference is made to individuals' electronic health records.	The list of professionally licensed persons who can render these covered services for purposes of Medicaid reimbursement has expanded to include supervisees, residents and eligibles. Providers' employees who are accessing the same electronic health records are required to meet the same requirements	To increase provider availability to avoid access to care problems. DMAS is moving towards accommodating providers' use of electronic health records

	Providers are required to inform the individual's primary care physician of the delivery of services and document such contact in the individual's record.	as if the record were on paper. Before such contacts may occur, the provider must obtain written permission of the individual to share such information with the primary care physician.	in other regulations and this change is consistent with that effort. This change is consistent with the consent and informing requirements of HIPAA.
12 VAC 30-60-143	QMHPs-Adult, QMHPs-Child, and QMHPs-Eligibles were allowed to conduct assessments. Intensive Community Treatment is limited to adults only.	This level of health care professional is not permitted by his license to conduct diagnostic activities. These professionals are allowed to render services, however, once a licensed professional has determined the individual's diagnosis. Adult only limit is removed.	Correction of drafting oversight. CMS directed DMAS to make this change.
12 VAC 30-130-2000 Definitions	Definitions did not include 'marketing materials'.	Definition is added.	To correct a drafting oversight.
12 VAC 30-130-3000 et seq.	Behavioral health Independent Clinical Assessment (ICA) requirements	ICA may be required for any of the services covered in either 12 VAC 30-50-130 or 12 VAC 30-50-226 with appropriate notice to providers.	To correct a drafting oversight.

Public comment

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

DMAS' proposed regulations were published in the February 11, 2013, *Virginia Register* (VR 19:12) for their comment period from February 11, 2013, through April 12, 2013. Comments were received from representatives of Rappahannock Area Community Services Board (CSB), D19 Community Services Board, Chesapeake Community Services Board, Henrico Area CSB, Virginia Association of Community Services Boards, Chesterfield CSB, Mount Rogers CSB, Horizon Behavioral Health, Harrisonburg-Rockingham CSB, Virginia Network of Private Providers, Inc., St. Joseph's Villa, Highlands CSB, Dominion Youth Services, Fairfax-Falls Church CSB, Loudoun County CSB, Prince William CSB, National Alliance for the Mentally Ill (Virginia Chapter), New River Valley CSB, Arlington County Department of Human Services/CSB Programs, Alex-

andria CSB, Middle Peninsula Northern Neck CSB and two individuals via the Regulatory Town Hall.

DMAS' summary of the comments received and the agency's responses are contained in the attached pages.

All changes made in this regulatory action

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

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
12 VAC 30-50-130		Sets out the amount, duration, and scope of community mental health services covered for children and adolescents under the authority of EPSDT. These services are: intensive in-home; therapeutic day treatment; community-based services (Level A); therapeutic behavioral services (Level B). Intensive In-Home (IIH) services were covered for an initial period before a prior authorization had to be obtained. QMHPs with specific years of experience were permitted to render counseling services. Provider provisional licenses are permitted. Clinical experience did not require that internships, practicums, and field experience had to be supervised. Case management is a component of IIH and Intensive Community Treatment (ICT).	Definitions are added. Professional personnel definitions correlate to licensing standards established by DBHDS, DSS or DOJ, as appropriate for the provider type. Provisional licenses will no longer be permitted. Prior authorization, before the onset of any of these services, is proposed. Standards are proposed for frequency of psychoeducational services; cases failing the standard will have payments retracted. When an individual no longer needs the required amount of psychoeducational services, he is to be moved to a less intensive level of care. Care coordination between different providers is required and must be documented. DBHDS agency name is updated. Case management is being removed from IIH and ICT due to 42CFR § 441.18 that prohibits case management from being a direct service. Service definition was revised to provide for care coordination which is less comprehensive than case management.

12 VAC 30-50-226		Sets out the amount, duration, and scope of community mental health services covered for both children and adults. These services are: day treatment/partial hospitalization; psychosocial rehabilitation; crisis services; intensive community treatment; crisis stabilization, and; mental health supports. QMHPs with specific years of experience are permitted to render counseling services. Case management is a component of IIH and Intensive Community Treatment (ICT).	Definitions are added to require professionals to meet licensing standards required by DBHDS in order to claim Title XIX reimbursement. Professional personnel definitions correlate to licensing standards established by DBHDS, DSS or DOJ, as appropriate for the provider type. Outdated reference to mental retardation is changed to intellectual disability due to federal law change. Service-specific provider intakes are proposed to support providers' claims for these services. Case management is being removed from IIH and ICT due to 42CFR § 441.18 that prohibits case management from being a direct service. Service definition was revised to provide for care coordination.
	12 VAC 30-60-5	New section.	Provides for general applicability of certain utilization review requirements for all Medicaid covered services. Provisional licenses prohibited. DBHDS' full annual, triennial or conditional license required of providers as well as DMAS provider enrollment agreement. Expenditure recoveries permitted when providers' documentation does not support claim(s) filed.
12 VAC 30-60-61		Specific assessment data elements are not required for IIH, Therapeutic Day Treatment and residential Levels A/B. The place of the assessment and the face to face requirement for IIH was not included. QMHPs are allowed to conduct assessments with a review by licensed MH professional for IIH and Therapeutic Day Treatment. Regs did not contain any caseload standards or supervision requirements for IIH or	Specific assessment data elements are proposed to ensure uniform and complete assessments. The place of the conduct of the IIH assessment must be in the home in order to evaluate family dynamics. LMHPs will be required to conduct IIH/Therapeutic Day Treatment assessments due to the acute nature of the service. DMAS is proposing to adopt the DBHDS licensing standards to promote improved quality of service delivery. Proposed marketing guidelines are intended to reduce/preclude inappropriate marketing activities by potential providers. Definition of LMHP was expanded to in-

		Therapeutic Day Treatment. No marketing guidelines existed. Definition of LMHP limited the number of licensed professionals that can render services for XIX reimbursement. No notification requirements for case managers or primary care providers. No provisions for service authorizations when lapses in services occurs.	clude the licensing board's standards for purposes of Title XIX reimbursement. Requirements are added for service notifications to case managers and primary care providers. Provision is made for service authorizations when temporary lapses of services occurs. Specific prohibition is proposed against providers copying the same progress notes from day to day. Provider documentation and supervision requirements are established to avoid payment retractions. Applicability of marketing restrictions established.
12 VAC 30-60-143		Providers must meet federal/state requirements for administrative and financial management capacity. Providers must document and maintain individual case records in accordance with requirements. Provider has to ensure free choice of providers to Medicaid individuals.	Service-specific provider intakes to be completed by certain professional license levels. Professionals who must periodically review the individual's Individual Service Plan are expanded by licensing type. Providers prohibited from copying previous progress notes to new dates of service and using generic suggested language published in publicly available publications. Provider documentation and supervision requirements are established to avoid payment retractions. Providers must comply with marketing restrictions and requirements. Coordination with case manager and primary care provider is proposed.
	12 VAC 30-130-2000	N/A	Rules are intended to control how providers will be permitted to market their services to potential Medicaid clients. Providers must secure DMAS' prior approval of marketing plans and can only distribute marketing literature to localities as permitted by their DBHDS' license. Providers may not offer money or non-monetary incentives to entice Medicaid clients into their caseloads or to retain them. Providers are specifically prohibited from using Medicaid clients' Protected Health Information to identify or market services. Providers are specifically prohibited from violating confidentiality of Medicaid clients' information. Providers are prohibited from conduct-

			ing service assessment activities at health fairs or other types of community events. Providers are prohibited from asserting that they are endorsed by Medicaid or any federal entity. Providers violating restrictions will be subject to the termination of their provider contracts for the services affected by the marketing activity or violation.
		N/A	New rules establish requirements and applicability of the Independent Clinical Assessment (ICA). In the absence of an ICA for designated services, those services will not be reimbursed.

SUMMARY OF PUBLIC COMMENTS

2011 Mental Health Program Changes for Appropriate Utilization and Provider Qualifications

12VAC 30-50, 12 VAC 30-60, and 12 VAC 30-130

DMAS' proposed regulations were published in the February 11, 2013, *Virginia Register* (VR 19:12) for their comment period from February 11, 2013, through April 12, 2013. Comments were received from representatives of Rappahannock Area Community Services Board (CSB), D19 Community Services Board, Chesapeake Community Services Board, Henrico Area CSB, Virginia Association of Community Services Boards, Chesterfield CSB, Mount Rogers CSB, Horizon Behavioral Health, Harrisonburg-Rockingham CSB, Virginia Network of Private Providers, Inc., St. Joseph's Villa, Highlands CSB, Dominion Youth Services, Fairfax-Falls Church CSB, Loudoun County CSB, Prince William CSB, National Alliance for the Mentally Ill (Virginia Chapter), New River Valley CSB, Arlington County Department of Human Services/CSB Programs, Alexandria CSB, Middle Peninsula Northern Neck CSB and two individuals via the Regulatory Town Hall.

DMAS is aware that these commenters submitted the same comments. Rather than repeating the agency's answers multiple times, DMAS has numbered them and, for repeated comments, is referring to this numbering system. A summary of the comments received follows:

Organization Name: Rappahannock Area Community Services Board

Comment 1a: The proposed regulations require that individuals be prescribed a psychotropic medication in the past 12 months in order to qualify to be approved to receive Mental Health Support Services (MHSS). This CSB has clients with diagnoses of Schizoaffective disorder and Schizophrenia who have refused their prescribed medications as a result of their mental health diseases. These individuals would not qualify for this service as proposed.

Comment 1b: The same commenter stated that a second concern was the discontinuation for MHSS of units over 5 hours of services. Staff is required to accompany some individuals to doctors' appointments some distance away and remain with them because of their mental health issues. The staff stays with the individuals so that they are aware of any changes to the individual's treatment plan. This commenter recommended that the 7-hours billing unit be restored. To better manage the number of such units, the commenter recommended that the provider be required to justify to the service authorization contractor the need for the 7 hour unit based on the client's needs per authorization period.

Response: The comments above involve a different regulatory package.

Comment 1c: This commenter also advocated for the Behavioral Health Services Administrator (BHSA) being removed as the pre-screener. The BHSA cannot be as fully informed about the individual, especially those who must be hospitalized, as the CSB. The BHSA, as a contractor for DMAS, has a financial interest in keeping individuals out of the hospital. This creates a conflict of interest. This could be a slippery slope in having a for-profit agency that is financially invested in the outcome being a primary decision maker (pre-screener) determining whether an individual should be hospitalized or not.

Response: The BHSA will have no financial interest in denying authorization and no conflicts of interest related to patient care or use of mental health services. DMAS employs many private contractors to perform agency functions, and the BHSA will be one of those contractors. The text will be edited to clarify that the BHSA will not operate as a pre-screener.

Organization: District 19 Community Services Board

Comment 2a: The proposed change to MHSS will impact our ability to provide this service due to reduced rates and reduced numbers of individuals who are eligible for this service. CSBs are required to provide services to eligible consumers regardless of their abilities to pay. Reducing rates not only impacts Medicaid recipients but also impacts our ability to serve the uninsured population. Reducing the basic limit to 4 units per day will impact our ability to cover the costs related to travel. District 19 CSB provides services to 9 localities in South Central Virginia thereby covering a large geographic area. Each trip to a consumer's location must provide the funding necessary to cover the costs of staffing and travel.

Comment 2b: An individual expressed concern about what the 'qualifying mental health diagnosis' may be defined as. The individual was concerned that it might be limited to 'affective or psychotic disorders, since they are not the only mental health population with significant impairments i.e. panic disorder, social phobia, conversion disorder'. This individual reported working with numerous clients who require significant assistance and encouragement to access available resources.

Some clients, who have frequent suicidal thoughts, mania, psychosis and refuse to use services due to paranoia, fear of negative consequences, and the nature of the mania, have to be constantly encouraged to access services. This commenter expressed concern about limiting MHSS to those clients who have had recent more serious interventions (such as hospitalization, temporary detention orders, residential treatment) since they may not have required more serious interventions because of the availability of MHSS to stabilize them.

Many clients have paranoia, co-occurring substance abuse, co-occurring developmental delays or cognitive issues that, in combination with mental health issues, result in lack of understanding of the need for medications, fear that others are trying to hurt them, fear of medications causing relapses to substance dependence such that they refuse medications or are chronically non-compliant.

DMAS should also consider client rights and how the criteria fit, or don't fit, client rights.

There needs to be thought given to mitigating the negative impact of limiting hours/units on providers and clients in rural areas with limited resources to meet mental health and medical needs. There must be a way to access providers or community resources even if the client is 1.5 to 2 hours away. The limitations to units would make it difficult to assist clients and could result in harm to clients who are significantly impaired. There should be the ability to approve overage units for those clients in rural areas even if the overage units progressively reduce over time in order to teach independence.

The commenter was concerned that the proposed changes, along with the reduction of mental health beds in hospitals and ability to access other services will result in increased legal issues for the community, jails instead of treatment, resurgence of hospitalizations, resulting in increased spending since services act as a protective factor to reduce these issues. The commenter stated that such changes could result in harm to clients as well as the community and was not in support of changing criteria to be so limited that clients that need the service cannot access it.

Response: These comments involve a different regulatory package.

Organization: Chesapeake Community Services Board

Comment 3: The proposed changes in reimbursement will significantly impact revenue with a decrease of about 50%. The original service definition described MHSS as 'training and support' and now the new definition describes it only as a 'training service'.

Some individuals who receive this service will no longer be eligible. This CSB has individuals living in the community whose recovery/training has been slow or intermittent so support services are required as the CSB continues to help them maintain their independence.

Response: These comments involve a different regulatory package.

Organization: Department of Behavioral Health and Developmental Services

Comment 4a: DBHDS also has a full license which needs to be included in DMAS' regs. DBHDS requires providers to have a license for emergency services/crisis intervention to provide Medicaid's Crisis Intervention services. Just having an outpatient license does not allow the provision of this service. DBHDS has the authority to determine staff qualifications and how part time experience is counted but DMAS does not. Only certified pre-screeners and LMHP should render crisis intervention services based on the level of clinical experience needed. QMHPs are not qualified to render this service. Intensive Community Treatment services should include rehabilitation and supportive services under the included services. Counseling/therapy should be a required element for Intensive In-home Services given the severe nature of mental health issues in children who qualify for this service.

Response: DMAS will incorporate the "full license" into the regulations, and will include the appropriate license types for Crisis Intervention services. DMAS will defer to DBHDS determinations on staff qualifications and part-time experience, including the DBHDS determination that only certified pre-screeners and LMHPs should render crisis intervention services. DMAS will refer to the DBHDS regulation setting forth the service elements for Intensive Community Treatment. DMAS will defer to the DBHDS requirement that counseling/therapy is a required component of Intensive In-Home Services.

Comment 4b: The current elements listed that need to be provided for Intensive In-Home services may not be clear. Alternative language was suggested.

Response: DMAS does not have the authority to add elements to the definition of Intensive In-Home services beyond what DBHDS requires. If DBHDS includes different elements in the future, DMAS will update its regulations to reflect those requirements.

Comment 4c: DBHDS has two different licenses for Crisis Stabilization. An Outpatient license does not qualify a provider to provide Crisis Stabilization services. To provide residential crisis stabilization services, a provider must have a Mental Health Residential Crisis Stabilization Service license. To provide community based crisis stabilization, a provider must have a Mental Health Non-Residential Crisis Stabilization Service license.

Response: DMAS will include the appropriate license types for Crisis Stabilization.

Comment 4d: DMAS currently requires an LMHP to perform the initial assessment for Intensive In-Home and MH Support Services which from a clinical and risk perspective, is less demanding than providing Crisis Stabilization services. An LMHP or Certified Prescreener level assessment should be required before the onset of Crisis Stabilization services.

Response: QMHPs are not permitted by their license to diagnose, which is a required element of the assessment. DMAS will incorporate this comment to require an LMHP or pre-screener level assessment before the onset of Crisis Stabilization services.

Comment 4e: The utilization review section only provides for adults. It should be expanded to also provide for children.

Response: DMAS will edit the regulation to clarify that the utilization review section applies to all CMHRS services.

Organization: Hall Community Services, Inc. (several individuals)

Comment 5a: Concern was expressed about a recent Medicaid memo requiring that only licensed LMHP professionals would be permitted to provide intake assessments for Mental Health Support Services to the exclusion of license-eligible professionals (LMHP-E). This agency serves a population for whom homelessness is a risk so it is critical to initiate services as soon as possible. A delay in providing an intake can easily lead to an individual becoming impossible to locate therefore going unserved.

Comment 5b: Concern was expressed for the proposed changes for what constitutes a 'history of qualifying mental health treatment'. Some individuals that the agency serves may not have been in a psychiatric hospital or residential treatment facility but are prescribed antipsychotic medication, see a psychiatrist, have been or are currently homeless and need significant training in independent living skills. Whether or not someone has been hospitalized or treated in a facility does not reflect that they are at imminent risk for such circumstances in the absence of services.

A change needs to be made to the requirement about medications being prescribed within the past 12 months. Individuals may have stopped taking their medications (as is common with this population) or the individuals may not have access to medical or psychiatric treatment in rural or remote areas. This requirement should not be included in the new regulations.

Comment 5c: An eligible licensed mental health professional (LMHP-E) should be able to continue conducting intake assessments as well as reassessments.

Comment 5d: Concern was expressed over the changes to qualifying mental health diagnoses, especially in regards to post-traumatic stress disorder (PTSD) and anxiety disorders. Concern was expressed that persons with diagnoses of PTSD, panic disorders, phobias, generalized anxiety disorders will fall through the cracks in getting the services that

they need. The physician determination process can be exhaustive and overwhelming. These conditions can be crippling. Persons with these diagnoses need one-on-one support and assistance with managing symptoms and living a life they want. Such persons need no roadblocks to services.

Response: These comments involve a different regulatory package.

Organization: Behavioral Health Quality Management Consulting

Comment 6: Multiple concerns were expressed.

1. The proposed name change to 'skill building' is suggestive of a developmental disability type of service. "While the primary focus of mental health supports is to assist individuals in development of daily living and other skills, the idea of a pure focus on training is indicative of a lack understanding of the complexity of dealing with individuals who have a serious mental illness."

2. There are circumstances when sessions exceeding 5 hours may be needed and should be permitted when accompanied with detailed documentation.

3. The requirement for a prescription for anti-psychotic or other psychiatric medication within the last 12 months will prohibit the admission to this service of many individuals who need it the most. The need to help this population access medical/psychiatric service and understand the need for medications seems to be one of the primary functions of this service.

4. Licensed Mental Health Professional-Eligible (LMHP-E) is not used in the proposed language regarding professionals permitted to conduct assessments. If LMHP-Es cannot perform assessments, it will dramatically slow down the ability of individuals to access much needed services. In the more rural areas of the state, there is a limited number of LMHPs to render assessments.

5. Limitations placed on admission for anxiety disorders seems to be contradictory to the requirement of individualized assessment and service planning. Admission should be based on need and functioning and not solely on diagnosis. PTSD and other anxiety disorders are debilitating and individuals with them require a vast amount of support.

"The individuals who receive mental health support services are frequently some of the neediest and most ignored of all populations. Virginia offers very limited services to this population and in an effort to save a nickel ends up spending dollars on jails, prisons, emergency room visits, and hospitalizations. When implemented correctly, mental health supports actually saves tax dollars, makes our communities safer and provided individuals with serious mental illness an actual path they can follow on the road to recovery."

Response: These comments involve a different regulatory package.

Organization: Creative Family Solutions, Inc.

Comment 7: Concern was expressed over the apparent removal of case management from the Intensive In-Home Service. Children needing this service may not be part of the community services board (CSB) system and these families can be resistant to change and intrusion into the family system regardless of need. Bringing in multiple providers into the family may have a negative effect and prevent the families from accepting services. The strong benefit of one provider coordinating services can be helpful for the child with linkage to CSB case management toward the end of services. Case management tends to be intensive at the start of services and then should subside over the 6 month period. In order to get well, the person must be in a safe home, have adequate food, get medical care are all typical link-and-referral services provided by case management. If an Intensive In-Home provider cannot do those things then treatment will be less successful.

Response: The Center for Medicare and Medicaid Services (CMS) has required DMAS to remove case management from Intensive In-Home Services and Intensive Community Treatment services. CMS has stated that case management cannot be bundled into any other service. DMAS is making this change to comply with a federal directive. Care coordination will replace case management as a component of these services.

Organization: Individual

Comment 8: Concern was expressed for the affected population over the cuts and changes proposed by DMAS. 'Severely mentally ill individuals greatly benefit from receiving MHSS and the taxpayers of Virginia benefit from the service as well. MHSS is in place to reduce inpatient psychiatric hospitalization and time spent in the jail system'. It is much less costly to care for individuals via Mental Health Support Services than to hospitalize them. The severely mentally ill population lack consistent positive social supports and lean on MHSS for assistance. The proposed changes will leave such clients with no supports and place the burden back on hospitals and the judicial system. This population will endure high rates of homelessness and emotional turmoil without the continuation of MHSS in its current capacity. This commenter urged consideration of the tax burden created by the hospitalization and incarceration of severely mentally ill persons who do not have the benefit of MHSS. Also, employees who work with the mentally ill population will be affected by job layoffs. This will hurt the local and state economy.

Response: These comments involve a different regulatory package.

Organization: Henrico Community Services Board

Comment 9a: The definition of 'activities of daily living' should be expanded to include shopping, budgeting, meal planning, etc. The definition of 'certified pre-screener' needs to conform to the *Code of Virginia*. The definition of 'service specific provider assessment' should reflect that the main focus is to determine mental health service needs and

appropriate level of service and general health information is to be gathered related to that.

Response: DMAS cannot change the definition of "activities of daily living" because the term is used across multiple agency services. References to activities of daily living are included in the eligibility criteria for services such as day treatment/partial hospitalization; psychosocial rehabilitation; crisis intervention; and crisis stabilization. The eligibility standards for these services are beyond the scope of this regulatory action.
The term "certified pre-screener" does not appear in the Code of Virginia. DMAS will clarify that the service-specific provider agreement obtains information about mental health status, and the severity, intensity, and duration of mental health care problems and issues.

Comment 9b: Regulatory wording regarding inadequate documentation resulting in payment retractions should provide that any failure needs to be significant and not minor and incidental or that documentation that is not 'in substantial compliance with the regulations' will result in payment denial.

Response: This proposal would allow subjective standards of "significant," leading to more litigation and inefficient use of time and resources for both providers and DMAS.

Comment 9c: With regard to the covered service crisis intervention, the regulation specifying what information is to be provided seems excessive. Providing name, Medicaid number, provider name and NPI and date of initiation of service should be sufficient. Predicting the 'amount of service that will be provided' is not practical. The regulation seems to require that certified pre-screeners deliver the service due to the 'and' in the definition implying that only CSBs or their designees can provide this service. This also appears in crisis stabilization.

Response: DMAS will incorporate this comment by removing from the registration requirement that providers submit the amount of service that will be provided. DMAS will allow providers to submit registration within one business day of the completion of the service-specific provider assessment.

Comment 9d: To qualify for Intensive Community Treatment (ICT), the standard should not be 'resistance to seek out and utilize appropriate treatment options' but should be more similar to that for in home services. The individual's ability to come into a clinic setting on occasion should not be a bar to getting the intensive services that are needed. The ability to keep a monthly or quarterly appointment does not connote an ability, willingness or appropriateness to come to a clinic setting multiple times a week.

Response: This comment concerns long-standing language that is not changing in this regulatory action. There is a choice of two criteria that the individual must meet in order to qualify for this service which are combined with a three-month history of need for the service.

Comment 9e: The requirement to inform the primary care provider about services being rendered should be qualified by 'with the permission of the individual or guardian'.

Response: Recipient consent is already required by both federal and state laws, which cover all CMHRS services. These regulations do not alter those statutory requirements but have been clarified on this issue.

Comment 9f: The regs should be clear that if a service provider and case manager are working from the same electronic or paper clinical record, that reporting requirements of the case manager are met. Duplicate reporting requirements should be eliminated.

Response: There are no reporting requirements for the case manager. The reporting requirements fall on the service provider, which must notify the case manager of provision of services. Documentation in the medical record must establish that notification occurred. The regulations are clarified on this issue.

Organization: Virginia Association of Community Services Boards

Comment 10a: Service providers should be able to employ part-time staff. Language could be added to the regulations permitting clinical experience that is the 'equivalent of' full time experience.

Response: DBHDS will define how providers should calculate part-time experience, and DMAS will direct readers to the DBHDS website for the Office of Licensure, where a document defines how experience should be calculated. DMAS will edit the text to clarify that experience may be full time experience or an equivalent amount of part-time experience, as established by DBHDS.

Comment 10b: Grandfathering and approved variances should be allowed to continue. If staff is qualified under the current regulations, they should be allowed to continue providing services using the verification/documentation of clinical and supervisory experience under the existing regulations.

Response: Past variances will remain intact in accordance with the prior policies set forth in the CMHRS manual. DMAS shall not grant any new variances and shall not grandfather in anyone who does not already meet the criteria and who does not already have a variance.

Comment 10c: Various sections indicate that 'incomplete, missing, or outdated' documentation will result in denied reimbursement. Such failures should be 'significant, not minor and incidental' in nature since the purpose of documentation review is to assure that a covered service is delivered to a covered individual in a clinically appropriate way. Documentation should not be used as a vehicle to deny legitimate reimbursement.

Response: Documentation is addressed in the response to 9b.

Comment 10d: There are a number of places where the proposed regulations seem to have removed person-centered planning language. Recipient planning and expressing preferences, goals, treatment options, etc., should be reflected throughout the regulations. Exchange of information about the recipient between providers should be based on the recipient's consent.

Response: DMAS fully supports person-centered planning and is endeavoring to conform all regulatory text to reflect person-centered planning principles. Recipient consent is addressed in the response to 9e.

Comment 10e: Sections that describe Activities of Daily Living seem to reflect more of a focus for developmental disabilities rather than behavioral health conditions. The suggestion was made that Instrumental Activities of Daily Living be added to these regulations.

Response: ADLs are addressed in the response to 9a.

Comment 10f: There needs to be a permitted exception process so that a recipient who, by his functioning or diagnosis, needs a more intensive level of service than what is available in the outpatient realm is able to receive it.

Response: DMAS must make service eligibility decisions consistently employing legally defined standards that are objectively verifiable and supportable when challenged. The use of subjective and flexible service eligibility criteria would create arbitrary, capricious, and legally unsupportable eligibility determinations. Providers are permitted/encouraged to re-assess an individual, at any time, that his needs/circumstances change.

Comment 10g: With regard to crisis intervention services, the provider should first provide a safe clinical setting for the individual and determines the initial level of care, level of risk, level of crisis, and risk of harm to self or others. Then the provider can register and document what is projected to be the needed level of care. This regulatory section needs additional thought and change.

Response: DMAS concurs with this comment. Registration is addressed in the response to 9c.

Comment 10h: DMAS should clearly separate the role of the CSB/BHAs mandated requirements in code from what is termed crisis stabilization and crisis intervention.

Response: DMAS does not have a separate service that covers only CSB-mandated functions. If CSBs use Medicaid services as a way to be reimbursed for mandated functions, CSBs must meet all requirements for these services. Any provider that bills DMAS for crisis stabilization or crisis intervention must meet Medicaid requirements for that service.

Comment 10i: In the Commonwealth, the term 'certified pre-screener' is exclusive to CSB/BHA clinicians who provide emergency services and pre-admission screening for

involuntary detention. The suggestion was made that the regulatory language be amended to precede 'certified pre-screener' with CSB/BHA if this is DMAS' intent.

Response: Pre-screeners are addressed in the response to 9a.

Comment 10j: In the definition of 'clinical experience', 'on a full-time basis' should be deleted. 'Clinical experience' should be the 'equivalent of' an amount that is full time. Parents and caregivers may need to work part time. There should be a flexible process for approval of an alternate degree.

Response: Part-time experience is addressed in the response to 10a. DBHDS will define what degrees may be considered "human services fields" and these comments may be directed to DBHDS.

Comment 10k: Language should be added to the definition of 'individual service plan' to reflect person-centeredness and ensure that the recipient is part of service planning.

Response: Person-centered planning is addressed in the response to 10d.

Comment 10l: In the definition of 'QMHP-A' and 'QMHP-C', grandfathering and variances should be continued because it would be critical in retaining staff to provide these services.

Response: Grandfathering and variances are addressed in the response to 10b.

Comment 10m: When CSB/BHA clinicians are addressing emergency situations, triage and stabilization should be allowed and followed by registration.

Response: Registration is addressed in the response to 9c.

Comment 10n: Please clarify 'service-specific provider assessment'. Is this the same as a comprehensive assessment and should it include the behavioral and primary health needs in 'health status'?

Response: The service-specific provider assessment is the same as a comprehensive assessment. Health status is addressed in the response to 9a.

Comment 10o: The amount of crisis intervention service that will be needed and provided cannot be determined at the onset of care. Individuals who are in crisis rarely provide comprehensive information so triage and stabilization are necessary before registration can occur.

Response: Registration is addressed in the response to 9c.

Comment 10p: Licensure through DBHDS for 'intensive community treatment' (ICT) is based upon the national PACT model. This service should remain as it is and DBHDS

should issue guidance to CSB/BHAs as to how licensure will be reconciled with the proposed changes. The language in the current regulation needs to be reworded to more accurately address the clinical profiles of individuals in need of ICT. The phrase 'demonstrates a resistance to seek out……' should be replaced with 'when services that are far more intensive than outpatient clinic care are required and services in the home and the community are more likely to be successful'.

Response: ICT and case management are addressed in the responses to 7 and 9d.

Comment 10q: The list of allowable activities for 'activities of daily living' should be expanded to include 'shopping, budgeting, meal planning, and medication management' which are important to individuals with serious mental illness. The definition of IADLs should also be added.

Response: ADLs are addressed in the response to 9a.

Comment 10r: The more stringent definition of 'at risk' may result in fewer children and adolescents with serious emotional disturbance qualifying for intensive in-home services. The outpatient, clinic-based services may not meet the need. Flexibility and an exception process are needed.

Response: Exceptions are addressed in the response to 10f.

Comment 10s: Regarding 12 VAC 30-120-143, primary care physician notification is agreed to as long as the recipient has consented to such notification.

Response: PCP notification is addressed in the response to 9e.

Organization: Chesterfield Community Services Board

Comment 11a: 'Certified pre-screener' is a term used for CSB/BHA clinicians who are trained and able to provide emergency service and pre-admission screening for involuntary hospitalizations. This term should only be used to refer to these professionals.

Response: Pre-screeners are addressed in the response to 9a.

Comment 11b: The regulations require clinicians to provide direct services on a full-time basis. Direct services should be dictated by education and experience.

Response: Part-time experience is addressed in the response to 10a. Staff qualifications are addressed in the response to 10j.

Comment 11c: Registering an individual in need of crisis intervention/stabilization should be allowed within some period of time after the beginning of the crisis period after an assessment can be completed.

Response: Registration is addressed in the response to 9c

Comment 11d: Activities of daily living should be expanded to include shopping, budgeting, meal planning, and medication management.

Response: ADLs are addressed in the response to 9a.

Comment 11e: Reimbursement should only be denied when there is substantial and significant incomplete, missing, or outdated documentation. When minor documentation infractions have occurred and a service has obviously been appropriately provided, it should be allowed for documentation to be corrected in the record.

Response: Documentation is addressed in the response to 9b.

Organization: Mount Rogers Community Services Board

Comment 12: 'Activities of daily living' should be expanded to include shopping, budgeting, meal planning, etc. 'Certified pre-screener' should be consistent with the *Code of Virginia* in that this is the responsibility of the CSB/BHA. 'Human service field' should include therapeutic recreation. Day treatment services and intensive in-home services should allow an LMHP-E (licensed eligible) professional to complete face-to-face assessments. Crisis intervention and crisis stabilization requirements for registration should be permitted within a period of time following the assessment.

Response: LMHP-Supervisees and LMHP-Residents will be permitted to complete assessments and other tasks assigned to LMHPs, providing that they are in continuous compliance with the Department of Health Professions' (DHP) regulations and guidance on supervised practice. ADLs and certified pre-screeners are addressed in the response to 9a. Human services fields are addressed in the response to 10j. Registration for crisis intervention is addressed in response to 9c. The same response also applies to crisis stabilization.

Organization: Horizon Behavioral Health (formerly Central Virginia CSB) and Mental Health/Substance Use Disorder Council of VACSB

Comment 13a: 12VAC30-50-226 A – Removes the CSB/BHA designation as the sole entity authorized to fill the role of 'certified pre-screener'. Conflicts with the current *Code of Virginia* § 37.2-505. Coordination of services for preadmission screenings and discharge planning and DBHDS licensing regulations (12 VAC 35-105-155). Expansion of pre-screening to include the BHSA – the BHSA will have a perceptual disincentive to hospitalize clients.

Response: Pre-screeners are addressed in the response to 9a. The BHSA is addressed in the response to 1c.

Comment 13b: 12 VAC30-50-226A – Behavioral Health Service Administrator: There needs to be a clear definition of this and who would have this distinction.

Response: The BHSA is addressed in response to 1c.

Comment 13c: 12 VAC30-50-226A - Requiring 'full time experience' will reduce the pool of potential staff and adversely affect recruitment of new professional staff (i.e., recent graduates, parents/caregivers working part time). No definition of 'supervision' is provided. 12VAC35-105-20 does not include calculation guidance for part-time employment. Define full time basis – a certain number of hours in a certain time frame?

Response: Part-time experience is addressed in response to 10a. Supervision requirements are established by DBHDS.

Comment 13d: 12VAC30-50-226A – Loss of person centered language concerning ISPs. Systems with Electronic Health Records (EHRs) will need time to reconfigure to meet new requirements – i.e., inclusion of discharge plan in ISP. Discharge plans are currently included in ongoing assessments.

Response: Person-centered language is addressed in response to 10d. Providers will have several months between the comment period and the date of the promulgation of these final effective regulations to make changes to systems for electronic health records.

Comment 13e: 12 VAC 30-50-226 A - For QMHP-A and QMHP-C staff, how will grandfathering and variances be handled related to staff already hired. Those previously QMPHA will stay QMPHA? (i.e., LPN retain their QMHP status) Person with just 4 years experience eliminated? Grandfathering for these? QMHP-A: Medicaid variance staff that were credentialed as QMHPs based on 4 years of experience up until February 2011 at which time the 4 years of experience was deleted.

Response: Grandfathering and variances are addressed in the response to 10b.

Comment 13f: 12 VAC30-50-226A – QMHP-C. Will variances be allowed for existing staff? Changes in Mental Health Worker category will reduce the pool of potential staff and adversely affect recruitment.

Response: Variances are addressed in the response to 10b.

Comment 13g: 12VAC30-50-226 A – Applaud addition of LSATP & LMFT. Current DMAS regulations as of 2/2012 include Psychiatric Nurse Practitioners as LMHPs. The psychiatric clinical nurse specialist will no longer be an obtainable specialty after 2013. Master level nurses are being educated and credentialed (board certified) to provide services to children, adolescents, and adults as nurse practitioners. The language will need to reflect both psychiatric clinical nurse specialist and psychiatric nurse practitioners as those of us who are currently double boarded will be grandfathered in.

Response: DMAS is required to utilize staff qualifications that are established by DBHDS and DHP. These comments can be forwarded to DBHDS.

Comment 13h: 12VAC30-50-226A – QPPMH. The following was removed from the definition, as a result to the reference to 12VAC35-105-20: 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, gerontology clients, or special education clients. The experience may include supervised internships, practicums and field experience.

Response: Staff qualifications are addressed in the response as to 13g.

Comment 13i: 12VAC30-50-226A – Registration - Adding another admin step to this process. Will need to add another staff position. Timeliness? What will the process be? How does filing a claim not already accomplish this? What will turnaround time be? Will CS (crisis stabilization) and Detox still be able to do a 24/7 admission if no one is at Key Pro?

Response: Registration is addressed in the response to 9c. Claims may be submitted within one year of provision of service, and inform DMAS of services that have been provided in the past. Registration will provide DMAS with information about services that an individual is receiving on a current basis, so that care can be better coordinated.

Comment 13j: 12VAC30-50-226B1 – Day Treatment/Partial Hospitalization. There is an additional requirement for the assessment: "The service-specific provider assessment, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community."

Response: The requirement that an assessment document how the individual meets the criteria for the service is already in place. This regulation simply reflects that reality.

Comment 13k: 12VAC30-50-226B1 – (b) "Exhibit such inappropriate behavior that the individual requires repeated interventions or monitoring by the mental health, social services, or judicial system that have been documented" -- documented by the provider or by the justice system? "e. These services may only be rendered by an LMHP, QMHP-A, QMHP-C, or a QPPM" – Will existing variances be honored?

Response: DMAS will edit the text to clarify that the interventions or monitoring shall be documented by the provider. Variances are addressed in the response to 10b.

Comment 13l: 12VAC30-50-226B: PSR. The CMHRS manual says that for Psychosocial Rehab, QMHP-s can conduct the assessment with approval by the LMHP, but the new definition of service specific provider assessment only mentions the LMHP. Clarification is needed that QMHP-A can continue to conduct the face-to-face assessment with LMHP approval. Will exist variances be honored? What about LPNs?

Response: QMHPs cannot diagnose, which is a required element of the assessment. DMAS will edit the text to clarify that service-specific provider assessments for Psychosocial Rehab must be conducted by an LMHP. Variances are addressed in the response to 10b. Staff qualifications (such as LPNs) are addressed in the response to 13g.

Comment 13m: 12VAC30-50-226B – Registration. Adding another admin step to this process. Timeliness? What will the process be? Amount of service that will be provided cannot be determined in advance. Many systems not set up for HIPAA compliant e-mail communication. Avoid duplication of services with whom? How does filing a claim not already accomplish this? Registering crisis service: assuming this can be done on-line, what if computers are down or staff cannot access the DMAS site? Crisis Intervention: clients in crisis, particularly if psychotic, cannot provide Medicaid information for registration.

Response: Registration is addressed in the response to 9c. The details of the registration process, including HIPAA-compliant communication methods, will be addressed during the design and implementation of the registration process. The difference between claims information and registration is addressed in the response to 13i.

Comment 13n: 12VAC30-50-226B – Crisis Intervention. Must staff now be both LMHP, QMHP-A or QMHP-C AND a certified pre-screener? In order to prevent duplication of services, there should be a requirement to register with DMAS only; what would be the purpose of registration? Should only be completed by a certified prescreener. Requiring that the evaluator be LMHP, QMHP and prescreener will squeeze many of the CSBs current staff out as our pre-screeners are not all licensed.

Response: DMAS will edit the text to clarify that staff shall be an LMHP or a certified pre-screener, but not both.

Comment 13o: 12VAC30-50-226B – ICT. Removing case management as a required component conflicts with the national PACT fidelity standards. The proposed definition of ICT also conflicts with DBHDS licensing regulations. CSBs/BHAs providing PACT services would experience a significant reduction in revenue as a result of eliminating case management from the bundled ICT service. Can CM be billed separately by the same provider? The PACT programs in Virginia depend on the currently bundled ICT revenue to sustain the programs. Therefore, many CSBs/BHAs would be forced to eliminate PACT services; consumers would lose a highly effective service, and there would be a corresponding increase in hospitalization rates. Individuals at this level of care required case management to assist with diversion from hospitalization and to assist with meeting basic needs. Case management should remain a component of this service.

Response: ICT and case management is addressed in the response to 7.

Comment 13p: 12VAC30-50-226B – ICT. What is a service-specific provider assessment? Clarification needed that QMHP-A can continue to conduct the face-to-face assessment with LMHP approval. Will existing staff qualification variances be honored? More stringent than DBHDS standards which require "c. One full-time vocational spe-

cialist and one full-time substance abuse specialist" who do not have to be QMHP-A or QPPMH.

Response: Service-specific provider assessments are addressed in the response to 10n. QMHPs cannot diagnose, which is a required element of the assessment. DMAS will edit the text to clarify that service-specific provider assessments for ICT must be conducted by an LMHP. Variances are addressed in the response to 10b. DMAS will edit the text to defer to DBHDS staff requirements for ICT service.

Comment 13q: 12VAC30-50-226B – Crisis Stabilization. Registration is adding another admin step in this process. Timeliness? What will the process be? Amount of service that will be provided cannot be determined in advance. Many systems not set up for HIPAA compliant e-mail communication. Avoid duplication of services with whom? How does filing a claim not already accomplish this? Will 24/7 admission be expected?

Response: Registration is addressed in the response to 9c. The details of the registration process, including HIPAA-compliant communication methods, will be addressed during the design and implementation of the registration process. The difference between claims information and registration is addressed in the response to 13i.

Comment 13r: 12VAC30-50-226B – Crisis Stabilization. Crisis Stabilization services regulations indicate that services are based on the assessment of a QMHP that are then later reviewed and approved by a LMHP within 72 hours. The LMHP is only reviewing and approving the service rather than performing a face to face assessment. Considering the acuteness and brevity of the service at 3 days the consumer is often discharged.

Response: Assessment requirements for Crisis Stabilization are addressed in the response to 4d.

Comment 13s: 12VAC30-50-226B – Crisis Stabilization. In order to provide the level of service that is needed for crisis stabilization services, the LMHP needs to be more actively involved in the assessment and treatment planning in the early stages of treatment which would then provide the information necessary for service authorization and also provide for more delineation of the service from crisis intervention and mental health supports. Must staff now be both LMHP, QMHP-A or QMHP-C AND a certified prescreener?

Response: Assessment requirements for Crisis Stabilization are addressed in the response to 4d. Staff qualifications are addressed in the response to 13n.

Comment 13t: 12VAC30-50-226B – PCP notification. Fully support coordination with PCP with client consent. Additional administrative step.

Response: Consent is addressed in the response to 9e.

Organization: Harrisonburg-Rockingham Community Services Board

Comment 14a: The definition of the 'service-specific provider assessment' does not take into account that a crisis intervention service can be provided by a certified pre-screener who may not be an LMHP. CSBs that have centralized intake will capture most, if not all, of the required information at the time of an intake. Having each service area capture all of the elements on their service specific assessments would be redundant for those individuals receiving multiple services simultaneously. LMHP level documentation for service specific assessments would not be in line with the current documentation credential requirements.

Response: Pre-screener/LMHP language is addressed in the response to 13n. DMAS will edit the text to clarify that pre-screeners may conduct assessments for services that include pre-screeners as qualified staff. Service-specific assessments are already required for each service even if individuals are receiving multiple services; this is not a change.

Comment 14b: Recommend adding 'either' to the definition of a 'certified pre-screener'.

Response: Pre-screener/LMHP language is addressed in the response to 13n.

Comment 14c: The regulations remove the CSB/BHA designation as the sole entity authorized to fill the role of certified pre-screener.

Response: CSB/BHA pre-screeners are addressed in the response to 9a.

Comment 14d: Regarding the definition of 'clinical experience', the full time experience requirement will reduce the pool of potential staff and adversely affect recruitment. The proposed definition does not allow for calculating full-time equivalent experience. The term 'supervised' needs further definition. Clarification is needed as to how documented proof of supervision is to be verified when hiring new staff. The ability to grandfather in current employees who meet the current regulations is needed.

Response: Part-time experience is addressed in the response to 10a. Supervision is addressed in the response to 13c. Grandfathering is addressed in the response to 10b.

Comment 14e: Regarding the definition of 'individual service plan', the inclusion of discharge planning is new. The proposed regulation does not allow for when an adult is unable/unwilling to sign his own ISP. Proposed regulations requiring the parent/guardian signature on the ISP do not take into account a child accessing mental health or substance abuse services without parental knowledge. There is no language about the individual being included in the development of his treatment plan.

Response: Discharge planning has always been a required component of ISPs. DMAS will edit the text to comply with Virginia Code § 44.1-2969, allowing minors to access mental health and substance abuse treatment without parental consent. Adults who lack the legal capacity to sign their ISP are already required to have a legal proxy sign in their place. In accordance with person-centered planning, DMAS permits adults and children

to decline to sign their ISP. DMAS will require providers to include the individual in the development of their treatment plan.

Comment 14f: The registration requirement needs clarification of the process and time frame for notification, needs clarification of purpose, adds an administrative step to clinical staff for a service provided 24/7 when client is under duress and administrative staff are not available.

Response: Registration is addressed in the response to 9c.

Comment 14g: With regard to psychosocial rehabilitation, clarification is needed that the QMHP is permitted to conduct the assessment with the LMHP's approval. The 30-day assessment period is not included or is there a different one?

Response: The assessment requirements for psychosocial rehabilitation are addressed in the response to 13l.

Comment 14h: With regard to the proposed 'service-specific provider assessment' and crisis intervention services the following points were made: (i) such an assessment would be a hindrance to providing very short term crisis service; (ii) persons in crisis are often unable to provide comprehensive information for such an assessment; (iii) is such an assessment needed when a pre-admission screening form is completed; (iv) a time frame for registration needs specification; (v) crisis stabilization is a 24/7 service; administrative staff is not always available so the assessment would add an administrative step for the clinical staff; (vi) insurance information is not always known at the time of the crisis intervention service, and; (vii) client is not always able to supply insurance information at the time of the crisis.

Response: The service-specific provider assessment is already required for crisis intervention; this is not a change. Registration is addressed the responses to 9c, 13i, and 13m.

Comment 14i: With regard to the proposed requirements for crisis stabilization the following points were made: (i) is a service-specific assessment needed when a pre-admission screening form is completed; (ii) a time frame for registration needs specification; (iii) crisis intervention is a 24/7 service; administrative staff is not always available so the assessment would add an administrative step for the clinical staff; (iv) insurance information is not always known at the time of the crisis intervention service; (v) client is not always able to supply insurance information at the time of the crisis, and; (vi) amount of service cannot always be determined in advance.

Response: The service-specific provider assessment is already required for crisis stabilization; this is not a change. Registration is addressed the response to 9c.

Comment 14j: The proposed definition of 'service-specific provider assessment' (i) does not account for the crisis intervention service being provided by a certified pre-screener who may not be an LMHP; (ii) CSBs have a centralized intake process that captures

most, if not all, of the proposed required information so having each service area capture the same information again creates redundancy; (iii) LMHP documentation for the service-specific assessments is not in line with the current document credential requirements.

Response: Pre-screeners are addressed in the response to comment 13n and 14a. The requirement for an assessment for each service is addressed in 14a.

Organization: Virginia Network of Private Providers, Inc.

Comment 15a: Regarding 12 VAC 30-50-130: (i) The definition of ADLs should include shopping, money management, meal planning, etc. (ii) QMHP-E should be included in the definition. (iii) 'Care coordination' has replaced 'case management' as a component of the intensive in-home service. Additional text was suggested.

Response: ADLs are addressed in the response to 9a. DMAS will add the definition of QMHP-E. The change from case management to care coordination was addressed in the response to 7.

Comment 15b: Regarding 12 VAC 30-50-226: (i) the Code requires that the pre-screening be performed by a designee of the local CSB; employees of the BHA would not qualify. (ii) The definition of human services field is not the same as in 12 VAC 30-50-130 and should be revised. There also needs to be a provision for grandfathering in all employees who have been hired under the current standards.

Response: Pre-screeners are addressed in the response to 9a. Human services fields are addressed in the response to 10j. Grandfathering is addressed in response to 10b.

Comment 15c: With regard to 12 VAC 30-60-5: (i) A comma needs to be added after 'full' to provide for licenses issued for less than three but more than one year.

Response: DMAS has incorporated this comment.

Comment 15d: With regard to 12 VAC 30-60-61: (i) the proposed language that intensive in-home assessments not being performed by a LMHP supervisee or resident is unnecessarily restrictive; (ii) the term 'duplicated' in C 5 is vague and open to interpretation by auditors. If progress notes should not be templates used for all or most participants is the concern, it should be so stated; (iii) in C 16, add text about the intensive in-home provider linking the individual and/or parent/guardian with needed services/supports in cases where case management is not being provided.

Response: LMHP-Supervisees and Residents are addressed in the response to 12. DMAS has already included the following sentence in the regulations to explain how to avoid duplicated notes, “Each progress note shall demonstrate unique differences particular to the individual’s circumstances, treatment, and progress.” Linking the individual to

needed services/supports is part of case management, which has been removed from IIH. This is addressed in the response to 7.

Organization: Individual

Comment 16: Many clients have co-occurring morbidities with their mental health issues, such as paranoia, substance abuse, developmental delay or cognitive issues, which result in a lack of understanding and fear of medications. Such clients often refuse psychotropic medications and can be chronically non-compliant. These clients still need services. DMAS should consider client rights and how these criteria fit into, or not, client rights. There needs to be thought given to the negative impact of limiting hours and units on providers and clients in rural areas where resources are limited. There must be the ability to access providers or community resources even if they are 1.5 to 2 hours away. While the end result of mental health support services is to support independence, there should be a way to approve overage units for those clients in rural areas.

Response: The comments above involve a different regulatory package.

Organization: St. Joseph's Villa

Comment 17a: Will QMHP-E and LMHP-E staff continue to be used based on the current CMHRS manual. These employees do not appear in the proposed regulations. Case management has been replaced with care coordination for Intensive In-Home Services. Does this mean that billable case management activities must be confined to work done with health care providers as opposed to the broader definition of case management which would vary based on the individual's need?

Response: LMHP-Supervisees and LMHP-Residents are addressed in the response to 12. QMHP-E is addressed in the response to 15a. Case Management is addressed in the response to 7. LMHP-Es have not been included because the licensing agency does not permit them. DMAS is not permitted to reimburse providers that are not licensed.

Comment 17b: For the Crisis Stabilization service, the proposed regulations indicate that the ISP must be completed within 24 hours of admission. Previously, the requirement was within 10 business days of the assessment. DBHDS regulations for Children's Residential Facilities allow 3 days from the date of admission to develop the ISP. This commenter proposed that ISP be completed within 72 hours of admission to align these regulations with the licensing requirements. Sometimes parents are unable to participate in the initial planning and to sign within the 24 hour timeframe.

Response: Children's residential facilities services can last for several months. Crisis stabilization services can last only up to 14 days. The requirement to produce the ISP within 24-hours is consistent with the short duration of the covered service. DMAS will edit the text to align the requirements for residential crisis stabilization with the DBHDS requirements in 12 VAC 35-46-740.

Organization: Highlands Community Services Board

Comment 18: This CSB is concerned about the changes proposed for mental health support services. This CSB provides mental health support services to 100 individuals who have serious mental illness. This service is one of the most vital services that assist these consumers to remain in their communities and to avoid repeated emergency room visits, hospitalizations or incarceration. If the proposed unit of service/rate changes, it will compromise this CSB's ability to provide this service to 100 clients. There is no other service that can substitute for MHSS except a more intensive service, which goes against the best practice of the least restrictive service.

Response: The comments above involve a different regulatory package.

Organization: Dominion Youth Services

Comment 19: The concern was raised about the elimination of case management from the definition of Intensive In-Home Services. No significant positive changes to this service are possible without increasing the rate. Best practices dictate that case management be provided to these affected families by the in-home worker. It is not a best practice to dictate that if case management is required, that another service worker be introduced into the family. The concern was that eliminating case management and requiring therapy and narrowing the definition of QMHP as well as maintaining the reimbursement rate will prohibit many providers from being able to provide this service.

Recent stakeholder meetings to discuss Mental Health Support Services were a model of public-private cooperation. Could this be done for Intensive In-Home Services?

Please reconsider the elimination of QMHP-E as our staff pool is quite limited. New graduates are eager to locate places where they can obtain clinical experience. Under the right supervision and an adequate training program, community mental health services can provide an excellent training ground.

Response: Case management is addressed in the response to 7.

Organization: Fairfax-Falls Church Community Services Board

Comment 20a: 12VAC30-30-60-143 – PCP: Support PCP Notification with appropriate client Authorizations in place.
12VAC30-50-130-5: Too many disciplines are being excluded. Nursing is not included as a human services field and should be noted in the list. How will staff hired under the current list of disciplines be grandfathered?
12VA30-50-130-5-ISP: Providers with EHR's will need time to reconfigure system capabilities to meet any new requirements. Discharge plans are currently included in a variety of ways including in ongoing assessments.

Response: PCP notification is addressed in the response to 9e. Human services are addressed in the response to 10j. EHRs are addressed in the response to 13d.

Comment 20b: 12VAC30-50-130-5 - Community Mental Health Services: Community Mental Health Services The term "certified pre-screener" is a term that, in Virginia, is considered to be exclusive to the CSB/BHA clinicians who provide emergency services and pre-admission screening for involuntary detention. This proposed change would be in conflict with the current Code of Virginia and DBHDS Licensing Regulations and removes the CSB/BHA designation as the sole entity to fill the role of certified prescreener.
12VAC30-50-130-5 - Intensive In-Home is one of the most intensive community cased (sic) mental health services provided to children and adolescents with serious emotional disorders (SED). SEDs are chronic conditions that persist over time and it is essential that children and adolescents with SED receive targeted case management services independent of IIH to ensure that clinical needs of these children and adolescents are being met effectively, coordinated and addressed.
12VAC30-50-130-5 - LMHP – Substance Abuse practitioners are certified not licensed. Does this mean that the CSAC will no longer be honored?

Response: Pre-screeners are addressed in the response to 1c and 9a. Case Management is addressed in the response to 7. Staff qualifications are addressed in the response to 13g.

Comment 20c:
12VAC30-50-130-5 - QMHP-C: How will grandfathering and variances be handled related to staff already hired – this is a critical issue. This change will impact the pool of potential staff and adversely affect recruitment.
12VAC30-50-130-5 - Requiring “full time experience” would reduce the pool of potential staff and adversely affect recruitment (i.e. caregivers, part-time workers). There is also need for guidance on the calculation of “clinical experience”. There needs to be a clear definition of the meaning of “supervised”. Also, what is the expectation of how internships, outside of the hiring entity, would be handled or documented?
12VA30-130-3010 - ICA: Removes the CSB/BHA designation as the sole entity authorized to perform independent clinical assessments.

Response: Grandfathering and variances are addressed in the response to 10b. Part-time experience is addressed in the response to 10a. Supervision is addressed in the response to 13c.

Comment 20d:
12VA30-130-3030A – Intensive In-Home: removes the CSB/BHA designation as the sole entity authorized to perform
12VA30-130-3030B – TDT: removes the CSB/BHA designation as the sole entity authorized to perform independent clinical assessments.
12VAC30-50-226 - Crisis Services: Crisis Intervention and Crisis Stabilization proposed requirements for "Registering" with DMAS should be expected only after the crisis intervention has been accomplished; within a designated timeframe. Additional information

about how the registration information will be transmitted to and used by DMAS, as well as staff training will need to be provided.

Response: CSBs were authorized to perform VICAP through a contract. However, the VICAP contract does not have an indefinite term, and DMAS anticipates the potential transfer of this function to the BHSA. Registration is addressed in the response to 9c and 13m.

Comment 20e:
12VAC30-50-226 - Day Treatment Services should allow LMHP-e (licensed eligible) to complete face-to-face assessments with approval/sign-off from a LMHP.
12VAC30-50-226 - Intensive In-Home Services should allow LMHP-e (licensed eligible) to complete face-to-face assessments with approval/sign-off from a LMHP.
12VA30-50-226 – ISP: Loss of person centered language is very concerning. This should be added back into this section as should the assurance that the recipient is part of service planning. In addition, providers with EHR's will need time to reconfigure to meet any new requirements.

Response: LMHP-Supervisees and LMHP-Residents are addressed in the response to 12. Person-centered planning is addressed in response to 10d. ISPs are addressed in the response to 14e. EHRs are addressed in the response to 13d. LMHP-Es are not allowed by the licensing agency. Reference to person-centered planning is added at 12 VAC 30-50-226 B.

Comment 20f:
12VA30-50-226 – ISP: Providers with EHR's will need time to reconfigure to meet any new requirements.
12VAC30-50-226A - Human Services Field: Too many disciplines are being excluded. Nursing is not included as a human services field and should be noted in the list. Degrees such as Therapeutic Recreation, Educational Psychology and others that cover requisite knowledge and skills are omitted, without option for special consideration. Flexibility in terms of exceptions should be built in. How will staff hired under the current list of disciplines be grandfathered?
12VAC30-50-226A - Clinical experience: Suggest deleting "on a full-time basis" or allow clinical experience to be the "equivalent of" an amount of full-time experience. Otherwise, the pool of providers is more severely limited than what it is now and recruitment will be affected. Parents and caregivers, for example, may need to work part-time. As well, there should be a flexible process remaining in the regulations for approval of an alternate degree.

Response: EHRs are addressed in the response to 13d. Human services fields are addressed in the response to 10j. Exceptions are addressed in the response to 10f. Grandfathering is addressed in response to 10b. Part-time experience is addressed in the response to 10a.

Comment 20g:

12VAC30-50-226A - Activities of Daily Living should be expanded to include shopping, budgeting, meal planning, etc.,
12VAC30-50-226A - The term "Certified Pre-screener" - should be consistent with the Code of Virginia. The proposed change would be in conflict with the current code of Virginia and DBHDS licensing regulations.
12VAC30-50-226A - Certified pre-screener: Suggest the language be amended in each section where it is used to be clear about the entity and the precise function. Do not use the term "certified pre-screener" unless it is accompanied by the prefix "CSB/BHA". Wording should be reworked to clarify the Certified Pre-screener role is exclusive to the CSB.BHA.

Response: ADLs are addressed in the response to 9a. Pre-screeners are addressed in the response to 1c and 9a.

Comment 20h:
12VAC30-50-226A – LMHP: After this year, we understand the Psychiatric Clinical Nurse Specialist will no longer be an obtainable specialty, as Masters' level nurses are now being educated and will be credentialed (board certified) to provide services to children and adults as Nurse Practitioners. The language needs to be corrected to reflect both psychiatric clinical nurse specialists and psychiatric nurse practitioners as those who are currently double board certified will be grandfathered.
12VAC30-50-226A – QMHP-A and C: How will grandfathering and variances be handled related to staff already hired – this is a critical issue. This change will impact the pool of potential staff and adversely affect recruitment.
12VAC30-50-226A – Registration: When CSB/BHA clinicians are addressing emergency situations, triage and stabilization, it should be clearly stated that the interventions are the priority, with Registration to follow.

Response: Nurse Specialists are addressed in the response to 13g. Grandfathering and variances are addressed in the response to 10b. Registration is addressed in response to 9c.

Comment 20i
12VAC30-50-226A – Registration adds another administrative step, which we believe is already accomplished by filing a claim. Based on this requirement, will Crisis Stabilization and Detox programs still be able to do 24/7?
12VAC30-50-226A – The details of the "Registration" process once the information is to be forwarded by the CSB/BHA need to be clarified, so CSBs can be able to advise individuals receiving services how the information will be used.
12VAC30-50-226A - Requiring "full time experience" work experience and not considering part-time experience would dangerously reduce the pool of potential staff and would adversely affect recruitment of many qualified people who have gained experience as caregivers or part-time staff.

Response: Registration is addressed in the response to 9c, 13i, and 13m. Part-time experience is addressed in the response to 10a.

Comment 20j:
12VAC30-50-226A – There is also need for guidance on the calculation of "clinical experience". There needs to be a clear definition of the meaning of "supervised". Also, what is the expectation of how internships, work outside of the hiring entity, would be handled or documented?
12VAC30-50-226B - Intensive Community Treatment: Licensure through DBHDS for this service is based upon the national PACT model. By removing case management as a required component of ICT, Virginia's regulations conflict with the national PACT fidelity standards. Individuals at this level of care require case management to assist with diversion from hospitalization and to assist with basic needs.
12VAC30-50-226B - Crisis Intervention: Amount of service that will be needed and provided can hardly be determined in advance. Individuals in crisis can rarely provide comprehensive information so triage and stabilization is necessary before registration of any kind. What will happen if the computers are temporarily down or for some other reason staff cannot reach DMAS? Individuals, in this case, may not always be able to provide Medicaid information for registration. As proposed, this registration would be completed only by a certified pre-screener, requiring that the evaluator would need to be an LMHP, QMHP and a pre-screener. This would disallow many of the CSB current staff to perform this service, since not all of our pre-screeners are licensed.

Response: The calculation of clinical experience is addressed in the response to 10a. ICT is addressed in the response to 7. Registration is addressed in the response to 9c. DMAS has not established staff qualifications for registration.

Comment 20k:
12VAC30-50-226B - Crisis Stabilization: Crisis Stabilization services regulations indicate that services are based on the assessment of a QMHP that are then later reviewed and approved by a LMHP within 72 hours. The LMHP is only reviewing and approving the service rather than performing the face to face assessment. Considering the acuteness and brevity of the service, at 3 days the consumer is often discharged. In order to provide the level of service that is needed for crisis stabilization services, the LMHP needs to be more actively involved in the assessment and treatment planning in the early stages of treatment, which would then provide the information necessary for service authorization and also provide for more delineation of the service from crisis intervention and mental health supports.
12VAC30-50-226B - Day Treatment Services: It is important that existing variances be honored.
12VAC30-5-226B - Psychosocial Rehab: As in other statements, will existing variances for Psychosocial Rehab be honored? What about for LPNs?

Response: Crisis stabilization is addressed in the response to 4d. Variances are addressed in the response to 10b. Staff qualifications are addressed in the response to 13g.

Comment 20l:

12VAC30-5-226B - QMHP-A: There is a need to clarify that a QMHP-A can continue to conduct the face to face assessment with the LMHP approval.
12VAC30-5-226B1 - Service-specific provider assessment: Please clarify and define what this is. Is this the same as a comprehensive assessment? Should the assessment include specifically the behavioral and primary health needs in health status?
12VAC30-50-226B5 - Crisis Stabilization must staff now be both LMHP, QMHP-A or QMHP-C and a certified pre-screener?
12VAC30-60-61A - Definition of "at risk": This more stringent definition in the proposed changes may easily result in fewer children and adolescents with SED qualifying for Intensive In-Home. If a service such as the Strategic Family Services and Supports Services Model were available, this definition may not have the potential to deny services to those who need them. That service is not in place, however, and outpatient, clinic-based services may not meet the need. Again, flexibility and an exception process are needed. This model is designed by the VACSB, endorsed by Voices for VA's Children.
12VAC30-60-143 - PCP Notification: With language that assures recipient's consent to the notification, fully support coordination with PCP.

Response: Staff qualifications for assessments are addressed in the response to 4d, 13l, and 13p. Service-specific provider assessments are addressed in the response to 10n. Pre-screeners are addressed in the response to 13n. The definition of "at risk" is substantially similar to the definition that is already in place, but broadens that definition to include a new category of individuals who may determine that the individual is at risk. The new definition is broader than the old definition. PCP notification is addressed in the response to 9e.

Fairfax-Falls Church Community Services Board

Comment 21: The Fairfax-Falls Church Community Services Board endorsed the general comments submitted by the Virginia Association of Community Services Boards.

- Both organizations understand the need to revise and tighten regulations to assure that those who need services receive them and that the services are of high quality.
- Some proposed changes in staffing seem unnecessarily burdensome and restrictive. For example, individuals who are qualified and wish to/must work part-time should not be excluded. Language could be added to provide that clinical experience could be the 'equivalent of' an amount of full time experience.
- Grandfathering in of existing staff and approved variances should be allowed to continue.
- Sections that state that incomplete, missing, or outdated documentation will result in denied reimbursement should be modified to provide that the failure is significant and not minor and incidental. The purpose of the documentation review is to assure that a covered service is delivered to a covered individual in a clinically appropriate way. Documentation should not be used as a vehicle to deny legitimate reimbursement.

- There are a number of places that appear to have changed or omitted the person-centered language that should remain if Virginia is to move into a person-centered health system. Recipient planning and expressing preferences should be reflected. Exchanges of information about recipients should expressly state that the recipient's consent is necessary.
- Instrumental Activities of Daily Living should be added to assist individuals with serious mental illness.
- A recipient who, via his functioning or diagnosis, needs a more intensive level of service than what is available in the outpatient realm should be able to receive the needed service through an exception process of forwarding the documentation to the pre-authorization contractor.
- Crisis Intervention services should be provided after the individual is triaged and in a safe clinical setting. Then Registration should occur.
- DMAS should clearly separate the role of CSB/BHAs mandated requirements in Code from what is termed Crisis Stabilization and Crisis Intervention.

Response: Part-time experience is addressed in the response to 10a. Grandfathering and variances are addressed in the response to 10b. Documentation is addressed in the response to 9b. Person-centered language is addressed in the response to 10d. ADLs are addressed in the response to 9a. Exceptions are addressed in the response to 10f. Registration is addressed in the response to 9c. Mandated functions are covered in the response to 10h.

Organization: Loudoun County Community Services Board

Comment 22a: 12VAC30-50-226A- The use of the term "certified pre-screener" is a term of art that, in Virginia, is considered to be exclusive to CSB/BHA clinicians who provide emergency services and pre-admission screening for involuntary detention. Under Virginia Code, no other entity can perform this function. Suggest the language be amended in each section where it is used to be clear about the entity and the precise function. Do not use the term "certified pre-screener" unless it is accompanied by the prefix "CSB/BHA".
12VAC30-50-226A- "Clinical experience": Suggest deleting "on a full-time basis" or allow clinical experience to be the "equivalent of" an amount of full-time experience. Otherwise, the pool of providers is more severely limited than what it is now and recruitment will be affected. Parents and caregivers, for example, may need to work part-time.
As well, there should be a flexible process remaining in the regulations for approval of an alternate degree.
12VAC30-50-226A- "ISP": Language should be added to reflect person-centeredness and assure that the recipient is part of service planning.

Response: Pre-screeners are addressed in the response to 1c and 9a. Part-time experience is addressed in the response to 10a. Alternate degrees are addressed in the response to 10j. Person-centered planning is addressed in the response to 10d. ISPs are addressed in the response to 14e.

Comment 22b:
12VAC30-50-226A-QMHP-A and C": Grandfathering and variances, as explained in the general comments, will be critical in retaining staff to provide these services.
12VAC30-50-226A-Registration: When CSB/BHA clinicians are addressing emergency situations, triage and stabilization should be allowed and followed by a Registration, as explained in our comments above.
12VAC30-5-226B1-Service-specific provider assessment: Please clarify. Is this the same as a comprehensive assessment? And should the assessment include specifically the behavioral and primary health needs in "health status"?

Response: Grandfathering and variances are addressed in the response to 10b. Registration is addressed in the response to 9c. Service-specific provider assessments are addressed in the response to 9a and 10n.

Comment 22c:
12VAC30-50-226B -Crisis Intervention: Amount of service that will be needed and provided can hardly be determined in advance. Individuals in crisis can rarely provide comprehensive information so triage and stabilization is necessary before registration of any kind.
12VAC30-50-226B "Intensive Community Treatment": Licensure through DBHDS for this service is based upon the national PACT model. We suggest this service remain as it is and that DBHDS issues guidance to CSB/BHAs as to how Licensure requirements will be reconciled with the proposed changes. Also, VACSB recommends that the language in the current regulation be reworded to more accurately address the clinical profiles of individuals in need of ICT. Delete the phrase "demonstrates a resistance to seek out and utilize appropriate treatment options" in Section 4.b. in the current regulations. Instead, insert the phrase "when services that are far more intensive than outpatient clinic care are required and services in the home and the community are more likely to be successful".
12VAC-50-130 - Activities of Daily Living: Proposed regulations state "Activities of daily living means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating." VACSB suggests that the list of allowable activities of daily living should be expanded to include shopping, budgeting, meal planning, and medication management, all of which are essential activities for individuals with Serious Mental Illness. As well, include the language for Instrumental Activity of Daily Living (IADLs).

Response: Registration is addressed in the response to 9c. ICT is addressed in the response to 7 and 9d. ADLs are addressed in the response to 9a.

Comment 22d:
12VAC30-60-61A-Definition of "at risk": This more stringent definition in the proposed changes may easily result in fewer children and adolescents with SED qualifying for Intensive In-Home. If a service such as the Strategic Family Services and Supports Services Model were available, this definition may not have the potential to deny services to those who need them. That service is not in place, however, and outpatient, clinic-based services may not meet the need. Again, flexibility and an exception process are needed.

12VAC30-60-143-PCP Notification: With language that assures recipient's consent to the notification, VACSB fully supports this provision.

Response: "At risk" is addressed in the response to 20l. Exceptions are addressed in the response to 10f. Notification is addressed in the response to 9e.

Organization: Prince William Community Services Board

Comment 23: The comments and concerns posted by the Virginia Association of Community Services Boards are the concerns of the Prince William CSB.

- Restricting qualifications of behavioral health staff must be balanced between the competency required for quality services with specific client groups and the decreasing pool of new people entering our profession. Grandfather staff who meet current DMAS qualifications.
- References to payment retractions should provide that retraction will result after failure to document substantial recording requirements and/or clear patterns of failure to document. Incidental failures are not uncommon.
- Persons with serious mental illness and persons with ID often need help with incidental activities of daily living, such as budgeting, shopping, travel training which should be included when 'activities of daily living' is used.

Response: Grandfathering is addressed in the response to 10a. Documentation is addressed in the response to 9b. ADLs are addressed in the response to 9a.

Organization: National Association on Mental Illness Virginia

Comment 24a: Families of people with mental illness who receive Medicaid funded services understand that revisions can be required to ensure quality and effectiveness. Virginia should adopt practice models for its intensive in-home service, therapeutic day treatment, mental health support services and crisis services to determine the types of interventions and outcomes that are needed so that families and service recipients know what to expect from the service and the provider.

Response: The comment suggests that DMAS implement practice models. Practice models are beyond the scope of this current regulatory package, but may be part of a future regulatory action.

Comment 24b: The BHSA has a financial interest in keeping individuals out of hospitals. There appears to be a conflict of interest with allowing the prescreener to be an employee of the BHSA.

Response: The BHSA is addressed in the response to 1c.

Comment 24c: In several places, the term 'care coordination' is added and 'case management' has been deleted. In other places, they are used simultaneously. Please clarify.

Response: Care coordination is defined in 12 VAC 30-50-130 as "collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care." Case management is defined in 42 CFR 441.18. Case management is addressed in the response to 7.

Comment 24d: Removing case management from Intensive Community Treatment conflicts with the licensure requirements through DBHDS as this service is a nationally-recognized PACT model. How will removing case management impact the service, licensure, billing, and service recipients?

Response: Case management is addressed in the response to 7.

Comment 24e: The definition of ADLs should include budgeting, money management, medical management, etc.

Response: ADLs are addressed in the response to 9a.

Comment 24f: Regarding the proposed marketing rules, this organization was pleased to see them and supported them.

Response: These rules grew out of the increase in inappropriate utilization of CMHRS services, which was often related to objectionable and misleading marketing practices. The marketing rules were established to help protect families from inappropriate marketing and to help curb inappropriate use of Medicaid services.

Organization: New River Valley Community Services

Comment 25: This CSB supported the comments made by Horizon Behavioral Health and Harrisonburg-Rockingham CSB.

12VAC30-50-226A Amend language to be clear that the term "certified pre-screener" continues to apply exclusively to CSB/BHA clinicians in their role of providing emergency services and pre-admission screening for involuntary detension (sic). Identify clinicians as "certified CSB/BHA pre-screeners."
12VAC30-50-226A Develop an equivalency consideration for full-time experience and a flexiblity (sic) consideration for alternative degrees to avoid severely limiting the pool of potential providers.
12VAC30-50-226A-QMHP-A and C - Grandfathering and variances will be essential to retaining staff to provide these services.
12VAC30-50-226B Continue licensure through DBHDS for ICT based on the PACT model. Consider language more appropriate to the client level of need such as "when services that are far more intensive than outpatient clinic care are required and services in the home and the community are more likely to be successful."

12VAC-50-130 Activities of Daily Living - Consider expanding elements of daily living to other basic need requirements for people with serious mental illness including shopping, budgeting, meal planning and preparation, and medication management.
12VAC30-60-61A The stringent definition of "at risk" may result in few children and adolescents with SED qualifying for Intensive In-Home. The absence of Intensive In-home services with this population weakens the outcomes of other services by creating significant service gaps. Outpatient and school-based services are not adequate to meet the needs of many of these clients.

Response: Pre-screeners are addressed in the response to 1c and 9a. Part-time experience is addressed in the response to 10a. Grandfathering and variances are addressed in the response to 10b. ICT is addressed in the response to 9d. ADLs are addressed in the response to 9a. "At risk' is addressed in the response to 20l.

Organization: Arlington County Department of Human Services/CSB Programs

Comment 26a:
12VAC30-30-60-143 – PCP: Support PCP Notification with appropriate client Authorizations in place.
12VAC30-50-130-5: Too many disciplines are being excluded. Nursing is not included as a human services field and should be noted in the list. How will staff hired under the current list of disciplines be grandfathered?
12VA30-50-130-5-ISP: ISP Providers with EHR's will need time to reconfigure system capabilities to meet any new requirements. Discharge plans are currently included in a variety of ways including in ongoing assessments.

Response: PCP notification is addressed in the response to 9e. Human services fields are addressed in the response to 10j. EHRs are addressed in the response to 13d.

Comment 26b:
12VAC30-50-130-5 - Community Mental Health Services: Community Mental Health Services The term "certified pre-screener" is a term that, in Virginia, is considered to be exclusive to the CSB/BHA clinicians who provide emergency services and pre-admission screening for involuntary detention. This proposed change would be in conflict with the current Code of Virginia and DBHDS Licensing Regulations and removes the CSB/BHA designation as the sole entity to fill the role of certified prescreener.
12VAC30-50-130-5 - LMHP: LMHP – Substance Abuse practitioners are certified not licensed. Does this mean that the CSAC will no longer be honored?
12VAC30-50-130-5 - QMHP-C: How will grandfathering and variances be handled related to staff already hired – this is a critical issue. This change will impact the pool of potential staff and adversely affect recruitment.

Response: Pre-screeners are addressed in the response to 1c and 9a. Staff qualifications are addressed in the response to 13g. Grandfathering and variances are addressed in the response to 10b.

Comment 26c:

12VAC30-50-130-5 - Work Experience: Requiring “full time experience” would reduce the pool of potential staff and adversely affect recruitment (i.e. caregivers, part-time workers). There is also need for guidance on the calculation of “clinical experience”. There needs to be a clear definition of the meaning of “supervised”. Also, what is the expectation of how internships, outside of the hiring entity, would be handled or documented?
12VA30-130-3010 - ICA: Removes the CSB/BHA designation as the sole entity authorized to perform independent clinical assessments.
12VAC30-50-226 - Crisis Services: Crisis Intervention and Crisis Stabilization proposed requirements for "Registering" with DMAS should be expected only after the crisis intervention has been accomplished; within a designated timeframe. Additional information about how the registration information will be transmitted to and used by DMAS, as well as staff training will need to be provided. Strongly recommend implementing EMTALA "like" guidelines if this moves forward

Response: Part-time experience is addressed in the response to 10a. Independent clinical assessments are addressed in the response to 20d. Registration is addressed in the response to 9c and 13m.

Comment 26d:
12VA30-50-226 – ISP: Loss of person centered language is very concerning. This should be added back into this section as should the assurance that the recipient is part of service planning.
12VAC30-50-226A - Human Services Field: Too many disciplines are being excluded. Nursing is not included as a human services field and should be noted in the list. Degrees such as Therapeutic Recreation, Educational Psychology and others that cover requisite knowledge and skills are omitted, without option for special consideration. Flexibility in terms of exceptions should be built in. How will staff hired under the current list of disciplines be grandfathered?
12VAC30-50-226A - Clinical experience: Suggest deleting “on a full-time basis” or allow clinical experience to be the “equivalent of” an amount of full-time experience. Otherwise, the pool of providers is more severely limited than what it is now and recruitment will be affected. Parents and caregivers, for example, may need to work part-time. As well, there should be a flexible process remaining in the regulations for approval of an alternate degree.

Response: ISPs are addressed in the response to 14e. Person-centered language is addressed in the response to 10d. Human services fields are addressed in the response to 10j. Part-time experience is addressed in the response to 10a.

Comment 26e:
12VAC30-50-226A - Certified Pre-screener: The term "Certified Pre-screener" - should be consistent with the Code of Virginia. The proposed change would be in conflict with the current code of Virginia and DBHDS licensing regulations.
12VAC30-50-226A - Certified pre-screener: Suggest the language be amended in each section where it is used to be clear about the entity and the precise function. Do not use

the term “certified pre-screener” unless it is accompanied by the prefix “CSB/BHA”. Wording should be reworked to clarify the Certified Pre-screener role is exclusive to the CSB.BHA.
12VAC30-50-226A – LMHP: After this year, we understand the Psychiatric Clinical Nurse Specialist will no longer be an obtainable specialty, as Masters’ level nurses are now being educated and will be credentialed (board certified) to provide services to children, and adults as Nurse Practitioners. The language needs to be corrected to reflect both psychiatric clinical nurse specialists and psychiatric nurse practitioners as those who are currently double board certified will be grandfathered.
12VAC30-50-226A – QMHP-A and C: How will grandfathering and variances be handled related to staff already hired – this is a critical issue. This change will impact the pool of potential staff and adversely affect recruitment.

Response: Pre-screeners are addressed in the response to 1c and 9a. Nurse specialists are addressed in the response to 13g. Grandfathering and variances are addressed in the response to 10b.

Comment 26f:
12VAC30-50-226A – Registration: When CSB/BHA clinicians are addressing emergency situations, triage and stabilization, it should be clearly stated that the interventions are the priority, with Registration to follow.
12VAC30-50-226A – Registration: Registration adds another administrative step, which we believe is already accomplished by filing a claim. Based on this requirement, will Crisis Stabilization and Detox programs still be able to do 24/7?
12VAC30-50-226A – Registration: The details of the "Registration" process once the information is to be forwarded by the CSB/BHA need to be clarified, so CSBs can be able to advise individuals receiving services how the information will be used.

Response: Registration is addressed in the response to 9c, 13i, and 13m.

Comment 26g:
12VAC30-50-226A - Work Experience: Requiring “full time experience” and not considering part-time experience would dangerously reduce the pool of potential staff and would adversely affect recruitment of many qualified people who have gained experience as caregivers or part-time staff.
12VAC30-50-226A – Clinical Experience: There is also need for guidance on the calculation of “clinical experience”. There needs to be a clear definition of the meaning of “supervised”. Also, what is the expectation of how internships, work outside of the hiring entity, would be handled or documented?
12VAC30-50-226B - Intensive Community Treatment: Licensure through DBHDS for this service is based upon the national PACT model. By removing case management as a required component of ICT, Virginia’s regulations conflict with the national PACT fidelity standards. Individuals at this level of care require case management to assist with diversion from hospitalization and to assist with basic needs.

Response: Part-time experience is addressed in the response to 10a. Clinical experience is addressed in the response to 20j. Supervision is addressed in the response to 13c.

Comment 26h:
12VAC30-50-226B - Crisis Intervention: Amount of service that will be needed and provided can hardly be determined in advance. Individuals in crisis can rarely provide comprehensive information so triage and stabilization is necessary before registration of any kind.
12VAC30-50-226B - Crisis Stabilization: Crisis Stabilization services regulations indicate that services are based on the assessment of a QMHP that are then later reviewed and approved by a LMHP within 72 hours. The LMHP is only reviewing and approving the service rather than performing the face to face assessment. Considering the acuteness and brevity of the service, at 3 days the consumer is often discharged. In order to provide the level of service that is needed for crisis stabilization services the LMHP needs to be more actively involved in the assessment and treatment planning in the early stages of treatment, which would then provide the information necessary for service authorization and also provide for more delineation of the service from crisis intervention and mental health supports.
12VAC30-50-226B - Day Tx: It is important that existing variances be honored.

Response: Registration is addressed in the response to 9c. Crisis Stabilization assessments are addressed in the response to 4d. Variances are addressed in the response to 10b.

Comment 26i:
12VAC30-5-226B - Psychosocial Rehab: As in other statements, will existing variances for Psychosocial Rehab be honored?
12VAC30-5-226B - QMHP-A: There is a need to clarify that a QMHP-A can continue to conduct the face to face assessment with the LMHP approval.
12VAC30-60-61A - Definition of "at risk": This more stringent definition in the proposed changes may easily result in fewer children and adolescents with SED qualifying for Intensive In-Home. If a service such as the Strategic Family Services and Supports Services Model were available, this definition may not have the potential to deny services to those who need them. That service is not in place, however, and outpatient, clinic-based services may not meet the need. Again, flexibility and an exception process are needed. This model is designed by the VACSB, endorsed by Voices for VA's Children.
12VAC30-60-143 - PCP Notification: With language that assures recipient's consent to the notification, fully support coordination with PCP.

Response: Variances are addressed in the response to 10b. Assessments for crisis stabilization, psychosocial rehabilitation, and ICT are addressed in the responses to 4d, 13l, and 13p.

Comment 26j: The Arlington County Community Services Board endorsed the general comments submitted by the Virginia Association of Community Services Boards.

- Both organizations understand the need to revise and tighten regulations to assure that those who need services receive them and that the services are of high quality.
- Some proposed changes in staffing seem unnecessarily burdensome and restrictive. For example, individuals who are qualified and wish to/must work part-time should not be excluded. Language could be added to provide that clinical experience could be the 'equivalent of' an amount of full time experience.
- Grandfathering in of existing staff and approved variances should be allowed to continue.
- Sections that state that incomplete, missing, or outdated documentation will result in denied reimbursement should be modified to provide that the failure is significant and not minor and incidental. The purpose of the documentation review is to assure that a covered service is delivered to a covered individual in a clinically appropriate way. Documentation should not be used as a vehicle to deny legitimate reimbursement.
- There are a number of places that appear to have changed or omitted the person-centered language that should remain if Virginia is to move into a person-centered health system. Recipient planning and expressing preferences should be reflected. Exchanges of information about recipients should expressly state that the recipient's consent is necessary.
- Instrumental Activities of Daily Living should be added to assist individuals with serious mental illness.
- A recipient who, via his functioning or diagnosis, needs a more intensive level of service than what is available in the outpatient realm should be able to receive the needed service through an exception process of forwarding the documentation to the pre-authorization contractor.
- Crisis Intervention services should be provided after the individual is triaged and in a safe clinical setting. Then Registration should occur.
- DMAS should clearly separate the role of CSB/BHAs mandated requirements in Code from what is termed Crisis Stabilization and Crisis Intervention.

Response: Part-time experience is addressed in the response to 10a. Grandfathering and variances are addressed in the response to 10b. Documentation is addressed in the response to 9b. Person-centered language is addressed in the response to 10d. Recipient consent to exchanges of information is addressed in the response to 9e. ADLs are addressed in the response to 9a. Exceptions are addressed in the response to 10f. Registration is addressed in the response to 9c. Mandated requirements are addressed in the response to 10h.

Organization: Alexandria Community Services Board

Comment 27a:
12VAC30-30-60-143 – PCP: Support PCP Notification with appropriate client Authorizations in place.
12VAC 30-50-130 B 5: Intensive In-Home (IIH) is one of the most intensive community-based mental health services provided to children and adolescents with serious emotional

disorders (SED). SEDs are chronic conditions that persist over time and it is essential that children and adolescents with SED receive targeted case management services independent of IIH to ensure that clinical needs of these children and adolescents are being met effectively, coordinated and addressed.
12VA30-50-130-5-ISP: Providers with EHR's will need time to reconfigure system capabilities to meet any new requirements. Discharge plans are currently included in a variety of ways including in ongoing assessments.

Response: PCP notification is addressed in the response to 9e. IIH case management is addressed in the response to 7. EHRs are addressed in the response to 13d.

Comment 27b:
12VAC30-50-130-5 - Community Mental Health Services: Community Mental Health Services The term "certified pre-screener" is a term that, in Virginia, is considered to be exclusive to the CSB/BHA clinicians who provide emergency services and pre-admission screening for involuntary detention. This proposed change would be in conflict with the current *Code of Virginia* and DBHDS Licensing Regulations and removes the CSB/BHA designation as the sole entity to fill the role of certified prescreener.
12VAC30-50-130-5 - LMHP: Substance Abuse practitioners are certified not licensed. Does this mean that the CSAC will no longer be honored?
12VAC30-50-130-5 - QMHP-C: How will grandfathering and variances be handled related to staff already hired – this is a critical issue. This change will impact the pool of potential staff and adversely affect recruitment.

Response: Pre-screeners are addressed in the response to 9a. Staff qualifications are addressed in the response to 13g. Grandfathering and variances are addressed in the response to 10b.

Comment 27c:
12VAC30-50-130-5 - Work Experience: Requiring "full time experience" would reduce the pool of potential staff and adversely affect recruitment (i.e. caregivers, part-time workers). There is also need for guidance on the calculation of "clinical experience". There needs to be a clear definition of the meaning of "supervised". Also, what is the expectation of how internships, outside of the hiring entity, would be handled or documented?
12VA30-130-3010 - ICA: Removes the CSB/BHA designation as the sole entity authorized to perform independent clinical assessments.
12VAC30-130-3010 A – IIH section: Removes the CSB/BHA designation as the sole entity authorized to perform independent clinical assessments.

Response: Part-time experience is addressed in the response to 10a. Clinical experience is addressed in the response to 20j. Supervision is addressed in the response to 13c. ICAs are addressed in the response to 20d.

Comment 27d:

12VAC30-50-226 - Crisis Services: Crisis Intervention and Crisis Stabilization proposed requirements for "Registering" with DMAS should be expected only after the crisis intervention has been accomplished; within a designated timeframe. Additional information about how the registration information will be transmitted to and used by DMAS, as well as staff training will need to be provided.
12VAC30-50-226 – Intensive In-Home Services should allow LMHP-E (licensed eligible) to complete face-to-face assessments with approval/sign-off from a LMHP.
12VA30-50-226 – ISP: Loss of person centered language is very concerning. This should be added back into this section as should the assurance that the recipient is part of service planning. Many Electronic Health Records (EHRs) will need time to reconfigure to meet any new requirements.

Response: Registration is addressed in the response to 9c and 13m. LMHP staff qualifications are addressed in the response to 12. Person-centered language is addressed in the response to 10d. ISPs are addressed in the response to 14e. EHRs are addressed in the response to 13d.

Comment 27e:
12VAC30-50-226A - Certified Pre-screener: The term "Certified Pre-screener" - should be consistent with the Code of Virginia. The proposed change would be in conflict with the current code of Virginia and DBHDS licensing regulations.
12VAC30-50-226A - Certified pre-screener: Suggest the language be amended in each section where it is used to be clear about the entity and the precise function. Do not use the term "certified pre-screener" unless it is accompanied by the prefix "CSB/BHA". Wording should be reworked to clarify the Certified Pre-screener role is exclusive to the CSB/BHA.
12VAC30-50-226A – QMHP-A and C: How will grandfathering and variances be handled related to staff already hired – this is a critical issue. This change will impact the pool of potential staff and adversely affect recruitment.

Response: Pre-screeners are addressed in the response to 9a. Grandfathering and variances are addressed in the response to 10b.

Comment 27f:
12VAC30-50-226A – Registration: When CSB/BHA clinicians are addressing emergency situations, triage and stabilization, it should be clearly stated that the interventions are the priority, with Registration to follow.
12VAC30-50-226A - Work Experience: Requiring "full time experience" and not considering part-time experience would dangerously reduce the pool of potential staff and would adversely affect recruitment of many qualified people who have gained experience as caregivers or part-time staff.
12VAC30-50-226B - Crisis Intervention: Amount of service that will be needed and provided can hardly be determined in advance. Individuals in crisis can rarely provide comprehensive information so triage and stabilization is necessary before registration of any kind.

Response: Registration is addressed in the response to 9c. Part-time experience is addressed in the response to 10a

Comment 27g:
12VAC30-50-130 – Activities of Daily Living: Proposed regulations state 'Activities of daily living means personal care activities and includes bathing, dressing transferring, toileting, feeding, and eating. VACSB suggests that the list of allowable activities of daily living should be expanded to include shopping, budgeting, meal planning, and medical management, all of which are essential activities for individuals with Serious Mental Illness. As well, include the language for Instrumental Activity of Daily Living (IADLs).
12VAC30-50-226 B 1: Service-specific provider assessment: Please clarify. Is this the same as a comprehensive assessment? And should the assessment include specifically the behavioral and primary health needs in 'health status'?
12VAC30-50-226B - QMHP-A: There is a need to clarify that a QMHP-A can continue to conduct the face to face assessment with the LMHP approval.

Response: ADLs are addressed in the response to 9a. Assessments are addressed in the response to 9a and 10n.

Comment 27h:
12VAC30-60-61A - Definition of "at risk": This more stringent definition in the proposed changes may easily result in fewer children and adolescents with SED qualifying for Intensive In-Home. If a service such as the Strategic Family Services and Supports Services Model were available, this definition may not have the potential to deny services to those who need them. That service is not in place, however, and outpatient, clinic-based services may not meet the need. Again, flexibility and an exception process are needed.
12VAC30-60-143 - PCP Notification: With language that assures recipient's consent to the notification, fully support coordination with PCP.

Response: At risk is addressed in the response to 20l. Exceptions are addressed in the response to 10f. PCP notification is addressed in the response to 10d.

Comment 27i: The Alexandria Community Services Board endorsed the general comments submitted by the Virginia Association of Community Services Boards.

- Both organizations understand the need to revise and tighten regulations to assure that those who need services receive them and that the services are of high quality.
- Some proposed changes in staffing seem unnecessarily burdensome and restrictive. For example, individuals who are qualified and wish to/must work part-time should not be excluded. Language could be added to provide that clinical experience could be the 'equivalent of' an amount of full time experience.
- Grandfathering in of existing staff and approved variances should be allowed to continue.

- Sections that state that incomplete, missing, or outdated documentation will result in denied reimbursement should be modified to provide that the failure is significant and not minor and incidental. The purpose of the documentation review is to assure that a covered service is delivered to a covered individual in a clinically appropriate way. Documentation should not be used as a vehicle to deny legitimate reimbursement.
- There are a number of places that appear to have changed or omitted the person-centered language that should remain if Virginia is to move into a person-centered health system. Recipient planning and expressing preferences should be reflected. Exchanges of information about recipients should expressly state that the recipient's consent is necessary.
- Instrumental Activities of Daily Living should be added to assist individuals with serious mental illness.
- A recipient who, via his functioning or diagnosis, needs a more intensive level of service than what is available in the outpatient realm should be able to receive the needed service through an exception process of forwarding the documentation to the pre-authorization contractor.
- Crisis Intervention services should be provided after the individual is triaged and in a safe clinical setting. Then Registration should occur.
- DMAS should clearly separate the role of CSB/BHAs mandated requirements in Code from what is termed Crisis Stabilization and Crisis Intervention.

Response: Part-time experience is addressed in the response to 10a. Grandfathering and variances are addressed in the response to 10b. Documentation is addressed in the response to 9b. Person-centered language is addressed in the response to 10d. Recipient consent is addressed in the response to 9e. ADLs are addressed in the response to 9a. Exceptions are addressed in the response to 10f. Registration is addressed in the response to 9c. CSB mandated functions are addressed in the response to 10h.

Organization: Middle Peninsula Northern Neck Community Services Board

Comment 28a: Service providers in large rural areas consistently face significant challenges recruiting and retaining qualified individuals to deliver quality behavioral health services. This difficulty is compounded when a service begins based on one set of criteria, including staffing credentials, and this changes in the future. Staff leaving through attrition from the system need to be replaced under the new credentialing criteria. This further compounds the difficulty.

Response: Staff qualifications are addressed in the response to 13g.

Comment 28b: Restricting clinical experience to individuals who performed in a full time capacity as contrasted against those who gained the same experience in a part time capacity seems discriminatory and narrowly focused. This further reduces the professional cadre of staff available for hire at a time of increased demand for services.

Response: Part-time experience is addressed in the response to 10a.

Comment 28c: Clinical experience should apply to experience gained in a part time basis and grandfathering and variances should be allowed to continue.

Response: Grandfathering and variances are addressed in the response to 10b.

Comment 28d: The need to provide thorough and comprehensive documentation was understood. The concern was expressed that the proposed regulations did not distinguish between significant errors that are clearly out of compliance and those of a more minor category. The distinction between significant errors and minor errors should be considered.

Response: Documentation is addressed in the response to 9b.

Comment 28e: Disagreement was expressed with expanding the certified prescreener designation to other entities as proposed. The *Code of Virginia* specifically limits CSB/BHA clinicians as the certified pre-screeners.

Response: Pre-screeners are addressed in the response to 9a.

Comment 28f: The definition of Activities of Daily Living was not supported as it reflected the needs of individuals with disabilities. It should be broadened to more accurately address the needs of individuals with mental health issues.

Response: ADLs are addressed in the response to 9a.

Comment 28g: Additionally, this commenter supported the comments made by the VACSB.

Response: Responses to comments from VACSB are addressed in the response to 10a through 10s.