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Final Regulation Agency Background Document

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

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

Brief summary

Please provide a brief summary of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

As the result of a court decision, DMAS has been required to change the requirements for inpatient psychiatric facilities (IPFs) and for providers who offer certain services (such as physician services, medical and psychologic services, vision, dental and emergency services) to residents of IPFs. The affected IPFs are freestanding psychiatric hospitals (both state hospitals and private hospitals) and residential treatment facilities (Level C). In order for these services to continue to be reimbursed separately from the per-diem rate paid to IPFs, the Centers for Medicare and Medicaid Services (CMS) requires that the IPF: 1) arrange for and oversee the provision of all services; 2) maintain all medical records of services provided under arrangement

furnished to the member residing in the IPF; 3) ensure that each member residing in an IPF has a comprehensive plan of care that includes services provided under arrangement; and 4) ensure that all services, including services provided under arrangement, are furnished under the direction of a physician. If these requirements are not met, DMAS will not reimburse for these services and providers may not charge members directly.

Statement of final agency action

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

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages entitled Institutions for Mental Disease Reimbursement Changes (12 VAC 30-50-130; 12VAC30-60-25; 12VAC30-70-201, 70-321, 70-415 and 70-417; 12VAC30-80-21; 12VAC30-130-850 through 890) 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 (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency’s overall regulatory authority.

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

For the preceding emergency regulations, DMAS acted based upon the 2012 *Acts of the Assembly*, Chapter 3, in which Item 307 CCC directed the agency to develop changes to requirements for non-facility services furnished to individuals residing in institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) in order to comply

with federal law. The 2013 *Acts of the Assembly*, Chapter 806, Item 307 CCC directed the agency to require that institutions of mental diseases provide referral services to their inpatients when the inpatients need services and to document such referrals and receipt of non-facility services.

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

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

Purpose

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

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

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

In response to that decision, and in accordance with CMS' guidance on the inpatient psychiatric benefit, DMAS implemented emergency regulations to permit separate billing for services (referred to by CMS and in the regulations as “services provided under arrangement”) when rendered to members under age 21 in IPFs when the IPF: i) arranges for and oversees the

provision of all services, including services furnished through contracted providers; ii) maintains all records of medical care furnished to these individuals; and iii) ensures that all services are furnished under the direction of a physician.

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

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

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both.

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

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

When a child is in an Inpatient Psychiatric Facility (either freestanding public/private psychiatric hospitals or residential treatment centers), under CMS' interpretation as a result of the referenced court order, these separate payments to the providers of professional services and for drugs are

not eligible for federal Medicaid matching funds unless the services are part of the inpatient psychiatric benefit. To be part of the inpatient psychiatric benefit and eligible for federal Medicaid matching funds, the IPF must oversee and arrange for these services, maintain the medical records of care furnished to these individuals and insure that services are furnished under the direction of a physician. If these requirements are met, DMAS may continue to directly reimburse providers of services under arrangement using existing reimbursement methodologies.

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

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

Services Provided Under Arrangement	Residential Treatment Centers Level C	Private Freestanding Psychiatric Hospitals	State Freestanding Psychiatric Hospitals
Physician Services	Yes	Yes	No
Other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	Yes	No
Outpatient Hospital Services	Yes	Yes	No
Pharmacy services	Yes	No	Yes
Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	Yes	No
Services Provided Under Arrangement	Residential Treatment Centers Level C	Private Freestanding Psychiatric Hospitals	State Freestanding Psychiatric Hospitals
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	Yes	No	No
Vision services	Yes	Yes	No
Dental and orthodontic services	Yes	Yes	No
Non-Emergency Transportation services	Yes	Yes	No
Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes	Yes

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

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

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

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

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

There are no localities that will be affected more than any others. These changes are to be applied uniformly statewide.

Family Impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one’s spouse, and one’s children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

Changes made since the proposed stage

*Please list all changes that made to the text of the proposed regulation and the rationale for the changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. *Please put an asterisk next to any substantive changes.*

No changes have been made since the proposed stage.

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. Please distinguish between comments received on Town Hall versus those made in a public hearing or submitted directly to the agency or board.

No comments were submitted during the proposed stage public comment period.

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. Explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12VAC 30-50-130		Under the emergency regulations, text requires IPFs to arrange for and maintain records of care furnished by outside providers and ensure that the services provided under arrangement and are included in the plan of care.	Changes between emergency and proposed stage: <ul style="list-style-type: none"> • In 30-50-130(B)(5)(d) and (e) the following phrase was added: "pursuant to 42 CFR 440.130." This phrase was added after discussions with CMS, in order to meet CMS requirements. • In 30-50-130(B)(6) was restructured to create three subsections (i, ii, and iii) to increase clarity.

			<ul style="list-style-type: none"> • In 30-50-130(B)(6)(b)(3), the phrase "as defined at 42 CFR 483.352" was added. This phrase was added after discussions with CMS, in order to meet CMS requirements. • In 30-50-130(B)(6)(b)(2), outpatient hospital services were added as item (ii) to include all services mentioned in the 6-9-14 Medicaid Memo on the changes. • In 30-50-130(B)(6)(b)(3), pharmacy services were added as item (ii), outpatient hospital services were added as item (iii) and durable medical equipment was added as item (vi). These changes were made to include all services mentioned in the 6-9-14 Medicaid Memo. • In 30-50-130(B)(6)(c), the phrases "the Code of Federal Regulations" and "specifically" and "the Conditions of Participation in 42 CFR Part 483 Subpart G" were added. These phrases were added after discussions with CMS, in order to meet CMS requirements. • In 30-50-130(B)(6)(d) the following sentence was added: "Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT." This sentence was added after discussions with CMS, in order to meet CMS requirements.
12VAC 30-60-25		Under the emergency regulations, new plan of care requirements are established. The regulations establish the specific requirements for freestanding psychiatric hospitals, the time frames under which the requirements must be met, and how non-compliance will be addressed during audits.	<p>Changes between emergency and proposed stage:</p> <ul style="list-style-type: none"> • In 30-60-25(C) the following sentence was added: "All Medicaid services are subject to utilization review/audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement." This sentence was added to clarify requirements. • In 30-60-25(C)(4), the phrase "written contractual" was added to the first sentence to clarify and to meet CMS requirements. • In 30-60-25((H)(7)(a), one business day was changed to three business days in response to a public comment that was received. (See public comment section, above.)
12VAC 30-70-		Under the emergency regulations, all services	No changes between emergency and proposed stages.

201		provided under arrangement can be billed separately only if they are included in the plan of care; if they are arranged and overseen by the freestanding psychiatric hospital; and if the medical records for such services are maintained by the freestanding psychiatric hospital in the individual's medical record.	
12VAC 30-70-321		Under the emergency regulations, the sections related to billing of services provided under arrangement were moved to a new section, 30-70-415.	No changes between emergency and proposed stages.
12VAC 30-70-415		Under the emergency regulations, all services provided under arrangement to freestanding psychiatric hospital patients can be billed separately only if they are included in the plan of care; if they are arranged and overseen by the freestanding psychiatric hospital; if the medical records for such services are maintained by the freestanding psychiatric hospital in the individual's medical record; and if the services are ordered by a physician.	No changes between emergency and proposed stages.
12VAC 30-70-417		Under the emergency regulations that are currently in place, all services provided under arrangement to RTC residents may be billed separately only if they are included in the plan of care; if they are arranged and overseen by the RTC; if the medical records for such services are maintained by the RTC in the individual's medical record, and; if the services are ordered by a physician.	No changes between emergency and proposed stages.
12VAC 30-80-21		Under the emergency regulations, billing for services furnished under arrangement in an inpatient psychiatric facility is subject	Changes between emergency and proposed stage: <ul style="list-style-type: none"> In 30-80-21, the following underlined phrase was <u>added</u>: "Reimbursement for all services furnished to individuals"

		<p>to special rules in 30-70-415 and 417.</p>	<p><u>younger than 21 years of age</u> who are ..."</p> <ul style="list-style-type: none"> In 30-80-21, the following underlined phrase was <u>removed</u>: "... and reimbursement of services provided under arrangement described in 12VAC30-80 <u>or elsewhere in the state plan.</u>" <p>Both changes were made to clarify requirements.</p>
<p>12VAC 30-130-850 through 890</p>		<p>Under the emergency regulations, the plan of care includes a list of services provided under arrangement, the prescribed frequency of treatment, and the circumstances under which treatment shall be sought. The regulations establish specific requirements for RTCs, the timeframes under which requirements must be met, and how non-compliance will be addressed during audit.</p>	<p>Changes between emergency and proposed stage:</p> <ul style="list-style-type: none"> In 30-130-850, definitions were added for "individual or individuals" and "inpatient psychiatric facility" and for "services provided under arrangement." These changes were made to add clarity to the regulations. In 30-130-890, a new section (A) was added to clarify requirements. In 30-130-890, the word "recipient" was changed to "individual" to add consistency to the regulations. In 30-130-890(H), the first sentence was stricken, as the content was moved to the new section A. Section 30-130-890(H) was restructured and renumbered to provide clarity. The text in Section 30-130-890(H)(6) was added to clarify requirements. In Section 30-130-890(L), the word "child" was changed to "individual" to add consistency to the regulations. The text in Section 30-130-890(M) was moved to Section 30-130-890(A).