Virginia Regulatory Town Hall

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# Proposed Regulation
# Agency Background Document

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| **Agency name** | Dept of Medical Assistance Services |
| **Virginia Administrative Code (VAC) citation** | 12 VAC 30, Chapters 50, 60, 80 and 120 |
| **Regulation title** | Amount, Duration and Scope of Medical and Remedial Services, Standards Established and Methods Used To Assure High Quality of Care, Methods and Standards for Establishing Payment Rates – Other Types of Care, and Waivered Services |
| **Action title** | Substance Abuse Treatment Services |
| **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 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

## Brief summary

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

This regulatory action establishes limited coverage of substance abuse treatment services for children and adults. The 2007 *Acts of Assembly*, Chapter 847, Item 302 PPP required that the Department of Medical Assistance Services (DMAS) amend the State Plan for Medical Assistance to provide coverage of substance abuse treatment services for children and adults, effective July 1, 2007. These services include emergency services; evaluation and assessment; outpatient services, intensive outpatient services, targeted case management; day treatment and opioid treatment services. Substance abuse services, with the exception of residential and day treatment services for pregnant and post partum women, were not offered prior to an emergency regulation promulgated by DMAS, which became effective July 1, 2007. The addition of these services fills a gap in the continuum of care for Medicaid enrollees.

MEDALLION Primary Care Case Management (PCCM) recipients now have substance abuse services covered by Medicaid. Unlike most other managed care Medicaid services, substance abuse services DO NOT require a referral by the primary care physician. Medallion II recipients who are enrolled in a Managed Care Organization (MCO) will have outpatient services

(excluding Intensive Outpatient Services) and assessment and evaluation services covered by the MCOs. All other mandated substance abuse services to be covered (Emergency Services (Crisis), Intensive Outpatient Services, Day Treatment Services, Opioid Treatment Services, and Substance Abuse Case Management services) have been carved-out of the services provided by the Medicaid MCOs and will now be covered as fee-for-service by DMAS.

## Legal basis

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

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

The 2007 *Acts of Assembly*, Chapter 847, Item 302 PPP requires that DMAS amend the State Plan for Medical Assistance to provide coverage of: substance abuse treatment services for children and adults including emergency services; evaluation and assessment; outpatient services; evaluation and assessment; outpatient services, also including intensive outpatient services; targeted case management; day treatment and opioid treatment services.

## Purpose

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

The purpose of this regulatory action is to establish coverage of basic substance abuse treatment services in the Medicaid Program. Substance abuse treatment services, with the exception of residential and day treatment services for pregnant and post partum women, were not previously a part of the State Plan. The addition of these services fills a gap in the continuum of care for Medicaid enrollees.

These current proposed regulations follow previously promulgated emergency regulations for substance abuse treatment for emergency services; evaluation and assessment; outpatient services, intensive outpatient services, targeted case management; day treatment and opioid treatment services for children and adults. The new services are modeled after existing mental health services for consistency. These new services provide needed resources for persons with substance use disorders. Additionally, studies have demonstrated that Medicaid reimbursement for substance abuse treatment produces savings benefits for both public safety and health. This

regulatory action will help protect the health, safety and welfare of Medicaid recipients by providing these new services.

## Substance

*Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the "Detail of changes" section.)*

The Medicaid State Plan sections affected by this regulatory action are Amount, Duration, and Scope of Medical and Remedial Services (12VAC 30-50), Standards Established and Methods Used to Assure High Quality of Care (12VAC 30-60), Methods and Standards for Establishing Payment Rates – Other Types of Care (12VAC 30-80), and Waivered Services (12 VAC 30-120).

Currently the Medicaid coverage provided for substance abuse treatment services is for pregnant and postpartum women only. The provisions are for residential treatment services and substance abuse day treatment. Residential treatment services for pregnant and postpartum women provides intensive intervention services in residential facilities other than inpatient facilities for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, thus achieving and maintaining a sober and drug free lifestyle. Substance abuse day treatment for pregnant and postpartum women provides intensive intervention services at a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week.

Substance abuse involves the use of illegal drugs, such as heroin and cocaine, as well as the overuse of alcohol, by both adults and children. Substance abuse can also involve the illegal use of prescription medications, by persons for whom this medication has not been prescribed. Persons for whom such prescription medications have been appropriately prescribed can also abuse their medications by using them beyond their treatment needs and by selling their prescriptions as street drugs. The substance abuse covered by this action does not include the use of tobacco or caffeine.

Medicaid provides coverage of existing services through managed care organizations as well as through fee-for-service. Medicaid recipients who live in areas of the state covered by managed care organizations (MCO's) are required to obtain their Medicaid covered services from the MCO's network of providers except if the recipient meets an MCO exclusion reason. Those Medicaid recipients who are excluded from participation in an MCO program and those recipients who live in areas of the state not covered by MCOs obtain Medicaid covered services from providers of their own choice who are enrolled with DMAS and paid under a fee-for-service method.

These proposed regulations for substance abuse treatment cover emergency (crisis) services; evaluation and assessment; outpatient services, intensive outpatient services, targeted case management; day treatment and opioid treatment services for children and adults. As noted

above, studies have demonstrated that Medicaid reimbursement for substance abuse treatment produces savings benefits for both public safety and health.

These new covered services will be defined as follows:

- **Emergency (crisis) services** – Immediate substance abuse care, available 24 hours a day, seven days per week to assist recipients who are experiencing acute dysfunction requiring immediate clinical attention.
- **Evaluation and assessment** – A structured interview documented as a written report which provides recommendations substantiated by findings of the evaluation and documents the need for the specific service.
- **Outpatient services** – individual, family, and group therapy, generally less than 3 hours per week.
- **Intensive out-patient services** – nonresidential setting provided to those recipients who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services.
- **Targeted case management** – a plan of care in effect which requires direct or recipient-related contacts or communication or activity with the recipient, family, service providers, or significant others, including at least one face-to face contact with the recipient every 90 days.
- **Day treatment services** - include the major psychiatric, psychological, and psycho-educational modalities that include individual, group counseling and family therapy, education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention, occupational and recreational therapy, or other therapies.
- **Opioid treatment services** – covers psychological and psycho-educational services for persons who need opioid therapy.

Treating substance abuse will lead to future savings for the Commonwealth. Studies confirm that every $1.00 spent on substance abuse treatment services generates savings of $7.00 in costs of unemployment, social services, health care, public safety, and other system-wide costs.

Additionally, the provision of Medicaid reimbursed substance abuse investment promotes a more efficient use of existing Medicaid expenditures. Studies also indicate that $1 out of every $5 Medicaid expends on hospital-based care is related to substance abuse and expanded community services will reduce these costs. There are no anticipated negative issues that will need to be addressed in the permanent regulations.

MEDALLION Primary Care Case Management (PCCM) recipients will have substance abuse services covered by Medicaid. These services are NOT subject to required referrals by the primary care physician. Medallion II recipients who are enrolled in an MCO will have outpatient services (excluding Intensive Outpatient Services) and assessment and evaluation services covered by the MCOs existing provider networks. All other mandated substance abuse services to be covered (Emergency Services (Crisis), Intensive Outpatient Services, Day Treatment Services, Opioid Treatment Services, and Substance Abuse Case Management services) will be carved-out of the MCO and covered by DMAS with a fee-for-service payment methodology.

Medicaid recipients who are not either MEDALLION or managed care participants will access these new services through their existing open access of DMAS-enrolled fee-for-service providers.

| Current section number | Proposed new section number, if applicable | Current requirement | Proposed change and rationale |
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| | 12 VAC 30-50-140 | N/A. | Provides a detailed description of outpatient substance abuse services, including service limitations, provider requirements and standards for medical necessity determinations. |
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| | 12 VAC 30-50-150 | N/A | Provides a detailed description of other provider types who may provide outpatient substance abuse services, including service limitations and provider requirements. |
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| | 12 VAC 30-50-180 | N/A | Provides a detailed description of provider types who may provide substance abuse services in a community mental health clinic setting. |
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| | 12 VAC 30-50-228 | N/A | Provides a detailed description of community substance abuse treatment services, including crisis intervention, day treatment services in non-residential settings, intensive outpatient services, and opioid treatment services. |
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| | 12 VAC 30-60-250 | N/A | Provides a detailed description of the utilization review as applied to community substance abuse treatment services, including medical necessity criteria for enrollees to receive these services as well as provider qualifications. |
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| | 12 VAC 30-50-491 | | Describes case management services for individuals who have an Axis 1 substance-related disorder. |
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| | 12 VAC 30-60-180 | | Describes utilization review of community substance abuse treatment services |
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| | 12 VAC 30-60-185 | | Describes utilization review of case management services |
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| | 12VAC30-60-255 | N/A | Provides a detailed description of case management services for adults who have an Axis 1 substance-related disorder, including a definition of the services, service limits and provider qualifications. |
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| | 12VAC30-80-32 | N/A | Reimbursement for substance abuse services: describes rate methodologies for substance abuse service providers, based upon Agency fee schedule and existing fees applied to current providers. |
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| 12VAC30-120-310. | | Services exempted from MEDALLION referral requirements. | Edits language to cover all substance abuse referrals. |
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| 12 VAC 30-120-380 | | Medallion II MCO responsibilities | Adds language regarding the services carved out of the MCO contract with DMAS, making MCOs responsible for outpatient services (excluding intensive outpatient services), and Assessment and Evaluation for substance abuse treatment. |

## Issues

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

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

The primary advantage to the public is that Medicaid participants will be able to receive certain Medicaid reimbursed substance abuse treatment services. Assisting individuals with recovery from substance abuse will benefit the individual, the family, and the community.

Treating substance abuse will lead to future savings for the Commonwealth. Studies confirm that every $1.00 spent on substance abuse treatment services generates savings of $7.00 in costs of unemployment, social services, health care, public safety, and other system-wide costs. Therefore, there are not expected to be any disadvantages for the public.

Additionally, the provision of Medicaid reimbursed substance abuse investment promotes a more efficient use of existing Medicaid expenditures. Studies also indicate that $1 out of every $5 Medicaid expends on hospital-based care is related to issues of substance abuse and expanded community services will reduce these costs.

The addition of these services will have a positive impact on health care providers as well. Both public and private providers will be eligible to enroll to render the substance abuse treatment services. Public providers and private practitioners are already accustomed to Medicaid's billing forms, service documentation requirements, and audit standards and practices.

DMAS has not identified any disadvantages to the public regarding this proposal.

## Requirements more restrictive than federal

*Please identify and describe any requirement of the proposal which are 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.*

The requirements of these proposed regulations are not more restrictive than applicable federal requirements.

## 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 are particularly affected.

## Public participation

*Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.*

In addition to any other comments, DMAS is seeking comments on the costs and benefits of these proposed regulations and the potential impacts of this regulatory proposal. Also, DMAS is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

**Anyone wishing to submit written comments may do so by mail, email or fax to:**

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Written comments must include the name and address of the commenter. In order to be considered, comments must be received by the last date of the public comment period.

## Economic impact

*Please identify the anticipated economic impact of the proposed regulation.*

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| **Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures** | For SFY 2008, $5,247,458 in GF was appropriated by the 2007 Appropriation Act for new SA services. This amount will be matched by $5,247,458 in federal funds. DMAS estimates that administration of the program will require $95,558 in general funds, with a match of $181,488 in federal funds. Administrative costs are for staff to perform prior authorization and utilization review for the new services. |
| **Projected cost of the regulation on localities** | There is no projected cost for localities. |
| **Description of the individuals, businesses or other entities likely to be affected by the regulation** | Individual providers, public and private providers, will be eligible to render these services and receive reimbursement from Medicaid. |
| **Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected.** Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million. | DMAS estimates that 765 providers would be eligible to render the new services. Many of these providers are small businesses who may choose to participate in the Medicaid program. It is estimated that more than half of the persons eligible to provide the services are small businesses. |
| **All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.** | The cost of recordkeeping for providers who elect to participate as providers would be covered in the payments made for the service. |

## Alternatives

*Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action.* ***Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.***

The Appropriations Act mandates coverage for the new services, therefore no other options were considered. DMAS involved stakeholders in the development of the emergency regulations and invites public comment on the current regulations. Whether or not to include intensive outpatient services within the responsibility of the Managed Care Organizations (MCOs) was considered. The benefit would be that MCOs have established provider networks. The negative was that this would create a different structure for substance abuse treatment reimbursement than that which currently exists for mental health day treatment. It was decided to keep the structure

as similar as possible for both mental health and substance abuse treatment. The impact of this decision will be monitored. It is possible that intensive outpatient services may be included as a responsibility of the MCOs at a later date.

A decision was made to cover opioid treatment as a distinct outpatient service due to the special need for this service. The intent of the Appropriations Act language is to cover this service, but it could have been covered as a part of outpatient services. By covering it separately, it ensures that the services needed by this special population will be met. These clients require daily visits and the proposed regulations were developed to meet the needs of this population.

Under the MEDALLION program, the addition of these covered services should be seamless. These services will be reimbursed as fee-for-service and, as an extension of the previous regulation that was limited to substance abuse coverage for pregnant women, no referrals to service providers by the primary care physician are required.

Under the Medallion II program, the decision of which services to carve-out and which to have covered by the MCOs was based on current coverage criteria for community mental health services. The MCOs will be responsible for coverage of assessment and evaluation, and outpatient services (excluding Intensive Outpatient Services). The substance abuse services carved-out of the MCO capitation fees and covered by DMAS under fee-for-service Medicaid include: emergency services (crisis), intensive outpatient services, day treatment services, substance abuse case management services, and opioid treatment services.

## Regulatory flexibility analysis

*Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.*

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DMAS invited input from providers and other stakeholders as the regulations were developed. This proposal includes changes recommended by stakeholders to improve the delivery of the new services. Documentation and billing procedures were modeled after current mental health services, to the extent possible, to minimize the impact on providers and promote simplification of service delivery.

## Public comment

*Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.*

The Agency published the emergency/NOIRA on June 25, 2007 (VAR 23:21) through July 25, 2007. The Agency has received comments, which are summarized below.

| Commenter | Comment | Agency response |
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| Substance Abuse Council | Assessment and counseling may be provided by a Qualified Substance Abuse Professional. | DMAS has included this recommendation in the State Plan Amendment and changed the language to "shall". |
| Substance Abuse Council | A higher level of education is being required for substance abuse case managers. The suggested level of education does not allow for the use of peer supports and does not support the recovery model. | DMAS has included this recommendation in the State Plan Amendment and will expand eligible providers of case management to include persons with a bachelor's degree in any field and who are a certified substance abuse counselor or certified addictions counselor. |
| Substance Abuse Council | Service limit for case management services is 52 *hours per year*. The reimbursement rate for mental health case management which is a flat rate of $326.50 per month which is significantly greater than the maximum rate allowable for Substance Abuse case management of $16.50 per 15 minutes or a maximum of $264 per month. If a limit is required, a monthly limit is recommended. | DMAS and the Department of Mental Health Mental Retardation, Substance Abuse Services (DMHMRSAS) believe this is a reasonable service limit, but will monitor utilization. The new structure for case management billing is required by CMS. |
| Substance Abuse Council | Except for a 30-day period following the initiation of this case management, the Medicaid recipient must be receiving another substance abuse treatment service. Page 19 of 26 Note: Requiring case management be linked to another Substance abuse treatment services does not support the recovery model of providing relapse prevention supports to persons as they transition into the community. This regulation fails to recognize the chronicity of addiction. Utilizing case management is cost effective because it can help minimize relapse, directing the at-risk consumer into less costly service before full-blown relapse occurs. | Federal regulations limit case management to linking, assessing and referral. Therefore, coordination of complex care is required. The minimum of 4 hours per week for intensive outpatient treatment was eliminated to allow providers to follow up with clients. |
| Substance Abuse Council | Monitoring and face-to-face support "may" be provided by a QSAP. QSAP or paraprofessional may provide education. Compliance measure is not clear. | DMAS has included this recommendation in the State Plan Amendment and specific functions were clarified. |
| Substance Abuse Council | The current rates for methadone are so low as compared to actual cost to the provider that this will act | DMAS modeled the rates after the current mental health services where possible. DMAS is including the rates for the new substance |

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| | as a disincentive for opioid treatment providers to utilize Medicaid. | abuse services in a study of mental health rates. Prescription drug costs may be billed separately from treatment costs. |

## 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 strengthen the authority and rights of parents in the nurturing, and supervision of their children by providing a new resource to them to improve the health of their children with substance use disorders. By improving health status these new services encourage children and adults to address substance use disorders and improve self-sufficiency, self-pride, and to assume responsibility for oneself, one's spouse, and one's children and/or elderly parents. It may strengthen the marital commitment by helping an individual address substance use disorders. It may help increase family income by enabling the individual to sustain recovery and employment.

## Detail of changes

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

*If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.*

| Current section number | Proposed new section number, if applicable | Current requirement | Proposed change and rationale |
|---|---|---|---|
| 12 VAC30-50-228 | | Regulation section does not address this service. | Intensive Outpatient Services must be provided a minimum of 4 hours and a maximum of 19 hours In order to allow clients to receive follow up services, the minimum requirement of 4 hours will be deleted. |
| 12 VAC 30-50-150<br><br>12VAC 30-50-180 | | Regulation section does not address this service. | Certified Substance Abuse Counselors with a Bachelors Degree are not an allowed provider of outpatient substance abuse treatment services Certified Substance Abuse Counselors with a Bachelors Degree under the direct supervision of a Medicaid enrolled qualified and licensed professional, will be allowed to provide outpatient substance abuse treatment services. This is consistent with State Code § 54.1-3507.1 |

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| 12 VAC 30-50-228 A(1)(b) | | Regulation section does not address this service. | States that certain functions may be provided by a QSAP, a certified pres-screener, or a paraprofessional. Changes language to shall to clarify which providers are approved to do certain functions. |
| 12 VAC 30-50-461 D (2) a | | Regulation section does not address this service. | Describes provider qualifications for case managers. Allows providers to qualify with a non-human services bachelor's degree with certification as a CSAC or a CAC. |
| 12 VAC 30-50-491 | | Deleted "significant others" in A and clarified that there is no case management billing in institutions for mental disease. | These changes were required by CMS. |
| 12 VAC 30-50-140 | | Clarified that services are under the direction of a physician. | This change was required by CMS |
| 12 VAC 30-50-180 | | Clarifies that a psychiatric nurse practitioner must be licensed. | This change was required by CMS |
| 12 VAC 30-50-228 A (1) &(2) | | Adds to the definition of services. | This change was required by CMS. |