REGULATORY REVIEW CHECKLIST

To accompany Regulatory Review Package

Agency Department of Medical Assistance Services

Regulation title Narrative for the Amount, Duration, and Scope of Services: Clinic Services

Purpose of the regulation To establish consistent provider qualifications to be applied to Community Services Boards mental health clinics.

Summary of items attached:

☒ **Item 1:** A copy of the proposed new regulation or revision to existing regulation.

☒ **Item 2:** A copy of the proposed regulation submission package required by the Virginia Administrative Process Act (Virginia Code Section 9-6.14:7.l.G [redesignated Section 9-6.14:7. l.H after January 1, 1995]). These requirements are:

- ☒ (i) the basis of the regulation, defined as the statutory authority for promulgating the regulations, including the identification of the section number and a brief statement relating the content of the statutory authority to the specific regulation proposed.
- ☒ (ii) the purpose of the regulation, defined as the rationale or justification for the new provisions of the regulation, from the standpoint of the public's health, safety and welfare.
- ☒ (iii) the substance of the regulation, defined as the identification and explanation of the key provisions of the regulation that make changes to the current status of the law.
- ☒ (iv) the issues of the regulation, defined as the primary advantages and disadvantages for the public, and as applicable for the agency or the state, of implementing the new regulatory provisions.
- ☒ (v) the estimated impact, defined as the projected number of persons affected, the projected costs, expressed as a dollar figure or range, for the implementation and compliance thereof, and the identity of any localities particularly affected by that regulation.

☒ **Item 3:** A statement from the Attorney General that the agency possesses, and has not exceeded, its statutory authority to promulgate the proposed regulation.

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☒ **Item 4:** A statement disclosing whether the contemplated regulation is mandated by state law or federal law or regulation, and, if mandated in whole or in part, a succinct statement of the source (including legal citation) and scope of the mandate, together **with an attached copy of all cited legal provisions.**

☒ **Item 5:** For any proposed regulation that exceeds the specific minimum requirements of a legally binding state or federal mandate, a specific rather than conclusory statement setting forth the reasoning by which the agency has concluded that the proposed regulation is essential to protect the health, safety or welfare of citizens or for the efficient and economical performance of an important governmental function.

☒ **Item 6:** For any proposed regulation that exceeds the specific minimum requirements of a legally binding state or federal mandate, a specific rather than conclusory statement describing the process by which the agency has considered less burdensome and less intrusive alternatives for achieving the essential purpose, the alternatives considered, and the reasoning by which the agency has rejected such alternatives.

☒ **Item 7:** A schedule setting forth when, no later than three (3) years after the proposed regulation is effective, the agency will initiate a review and reevaluation of the regulation to determine if it should be continued, amended, or terminated. Include a description of the specific and measurable goals the proposed regulation is intended to achieve, if practical.

☒ **Item 8:** A detailed fiscal impact analysis prepared in coordination with DPB that includes: (a) the projected cost to the state to implement and enforce the proposed regulation and (b) the source of funds to meet this projected cost.

/s/ Dennis G. Smith	6/3/1999	6/3/99 VPS
Signature of Agency head	Date	Date forwarded to DPB & Secretary

REGULATORY REVIEW SUMMARY

Amendment to the Plan for Medical Assistance

I. IDENTIFICATION INFORMATION

Title of Proposed Regulation: Narrative for the Amount, Duration, and Scope of Services: Qualifications for Community Mental Health Clinic Providers

Director's Approval: June 3, 1999

Public Comment Period:

Proposed Effective Date: September, 1999

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II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, §32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, §32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) §§9-6.14:7.1 and 9-6.14:9.1, for this agency's promulgation of proposed regulations subject to the Governor's review.

The Notice of Intended Regulatory Action for this regulation was filed with the Virginia Register on November 2, 1998, and had the mandatory 30-day comment period which ended October 23, 1998.

The Code of Federal Regulations, Title 42 Part 440.90, defines clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(a) Services furnished at the clinic by or under the direction of a physician or dentist;

(b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

Purpose: The purpose of this proposal is to establish provider qualifications, to be applicable to public community mental health clinics, to ensure that the mental health therapy services rendered to recipients are provided by appropriately qualified and supervised medical professionals. The intent of these requirements is to prevent the development of a two-tiered system of health care: a higher level for privately paying or insured individuals and a lower quality for Medicaid recipients. Maintaining a consistent quality of health care, without regard for source of payment, will directly improve the mental health care services Medicaid recipients receive.

Substance and Analysis: The sections of the State Plan affected by this action are the Narrative for the Amount, Duration, and Scope of Services, Clinic Services (12 VAC 30-50-180).

Department of Medical Assistance Services (DMAS) Program Compliance reviews have illustrated that some CSBs are uncertain about DMAS' policy with regard to the qualifications of therapists in community mental health clinics, primarily Community Service Boards. Because of this confusion, CSBs are constantly asking DMAS for clarification of policy on qualified therapists. Therefore, it is necessary to clarify DMAS' policy and ensure that DMAS is billed only when psychotherapeutic services are rendered by staff with appropriate training and supervision.

When psychotherapy services are provided in a private practitioner's office, only specifically licensed personnel are allowed reimbursement for these services. However, state law allows mental health clinics to use non-licensed personnel. Both DMAS and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) have recognized the need to provide clear guidelines for community mental health clinics on minimum staff qualifications which will entitle those clinics to qualify for Medicaid reimbursement.

To address these concerns, a work group comprised of staff from DMAS and DMHMRSAS met to develop clear guidelines on qualifications for staff providing Medicaid-reimbursable psychotherapy services in community mental health clinics. DMHMRSAS raised several concerns about the implementation of the provider credential requirements - the fiscal impact on the CSBs and access to care. Both of these concerns can be resolved by establishing a grace period during which the CSBs can convert caseloads to those staff who meet the DMAS standards. The provider standards included in this regulation are the result of this work group and have been shared with CSBs for input.

Additional questions have arisen regarding the requirement that licensed providers be supervised by a physician. DMAS recently promulgated regulations allowing Licensed Professional Counselors (LPCs) and Licensed Clinical Social Workers (LCSWs) and licensed Clinical Nurse Specialists-Psychiatric (CNS) to directly enroll and receive reimbursement as Medicaid providers. The provisions regarding direct reimbursement and supervision of LPCs, LCSWs, and CNSs by Medicaid do not affect the CSBs. CSBs are providers enrolled with Medicaid as mental health clinics.

By federal definition as discussed above, clinics must be physician directed. So DMAS cannot remove the supervision requirements for individuals providing services in mental health clinics run by CSBs. In addition, reimbursement for clinics is calculated differently than reimbursement for private practitioners. The individual clinicians employed within a clinic are not reimbursed by Medicaid; the clinic is reimbursed. The clinic then pays its employees or contractors. The way independent practitioners are reimbursed does not affect reimbursement to individuals providing services in a clinic setting, so independent practitioners will not be affected by these proposed regulations.

This regulation will allow a period of 24 months for the community mental health clinics to comply with these more specific provider requirements. Because of this transition period, DMAS does not anticipate a negative fiscal impact on the CSBs. The transition period will also allow the clinics to arrange for enough qualified staff so that the current level of access to care will not be jeopardized. This change will not result in any changes to the number of recipients or families being served. This change is budget neutral.

Issues: The primary advantage to recipients is that the individuals who provide psychotherapy services will be appropriately qualified and supervised. This will prevent individuals who obtain psychotherapy services from public mental health clinics from receiving a lesser quality of care than privately paying or insured individuals. This will have no impact on private sector licensed physicians and licensed clinical psychologists. The Community Services Boards will be required to hire upgraded staff and to provide appropriate physician supervision in order to be reimbursed by DMAS. Therefore, the agency projects no negative issues involved in implementing this proposed change.

Fiscal/Budget Impact: This regulatory change is targeted to community mental health clinics and affects providers in public community mental health clinics (those administered by local community services boards of the Department of Mental Health, Mental Retardation, and Substance Abuse Services.) The change will allow a period of 24 months for these clinics to comply with the more specific provider requirements. Because of this transition period, DMAS does not anticipate a negative fiscal impact on the clinics. There is no additional cost of implementation or enforcement, and no costs of compliance to the public.

During state Fiscal Year 1998, DMAS paid 42 mental health clinic providers $3.6 million dollars for psychotherapy services. These providers filed 75,514 claims for services during this time period for services rendered to 15,672 individuals. No significant change in the number of filed claims is expected. There are no localities that are uniquely affected by these regulations as they apply statewide.

Funding Source/Cost to Localities/Affected Entities: The 40 CSB community mental health clinics will be required to hire upgraded staff and to provide appropriate physician supervision in order to be reimbursed by DMAS, so there will be some additional costs to localities. Consequently, there may be additional costs to some localities although there is no available data identifying which localities, and what their costs might be. There are some localities already implementing the spirit of these proposed regulations so no additional costs will accrue to them.

For those CSBs, which do need to expend money to hire licensed staff, the two-year grace period may be used to generate extra funds to offset the additional costs and to adjust their appropriations requests.

This proposed regulation would have no impact on local departments of social services because it does not affect persons eligible for Medicaid covered services nor the eligibility determination process. Because the services will be provided by staff that is licensed, affected families will benefit from more experienced and credentialed staff.

Forms: No new forms are required to implement this proposed regulation.

Evaluation: DMAS routinely monitors the implementation of State Plan changes to assure policy conformance. DMAS will include this policy in its ongoing Plan management monitoring activities.

III. STATEMENT OF AGENCY ACTION

I hereby approve the foregoing Regulatory Review Summary and the attached amended pages to the State Plan for Medical Assistance for publication for public comment period in conformance to the public notice and comment requirements of the Administrative Process Act, Code of Virginia §9-6.14:7.1., Article 2.

June 3, 1999
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services

JUSTIFICATION FOR PROPOSED REGULATORY CHANGE
Under Executive Order Twentyfive (98)

I. IDENTIFICATION INFORMATION

Regulation Name: Narrative for the Amount, Duration, and Scope of Services: Clinic Services

Issue Name: Qualifications for Community Mental Health Clinic Providers

II. JUSTIFICATION

Federal/State Mandate/Scope

The legal authority of the Agency to administer the Medicaid Program is as stated above (II.). This regulatory change is not the result of a federal or state mandate. This regulation is necessary to assure that quality psychotherapy services are provided to Medicaid recipients in a community mental health clinic setting and to reduce confusion among providers about staff qualifications to receive Medicaid reimbursement. It is also intended to reduce the recovery actions that Medicaid must undertake against Community Services Boards when they have been paid for psychotherapy services rendered by inadequately qualified and supervised staff.

Essential Nature of Regulation

This regulatory action is essential for the efficient and economical performance of an important governmental function because without it DMAS will lack the authority to recover funds expended for psychotherapy services when such services have been rendered by inadequately qualified and inappropriately supervised staff.

Agency Consideration of Alternatives

The proposed change is the product of recommendations derived from a work group of affected parties. The group was comprised of representatives of local community services boards, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and DMAS.

The group's intent was to clarify and give guidance to those local community services boards that provide these mental health services and subsequently seek Medicaid reimbursement. The group's intent also was to ensure that the services were provided by appropriately qualified personnel. The alternative in lieu of these regulations would be to make no changes, thus resulting in a continuation of problems with reimbursement, issues of service quality, and the possibility of a two-tiered system of care.

Family Impact Assessment (Code of Virginia §2.1-7.2)

No negative impact is expected for families. The proposed regulations will improve the level of care available for recipients because it specifies that all providers of care must be appropriately trained.

Regulation Review Schedule

The regular review of this regulation will occur in conjunction with the review of all agency regulations according to the schedule approved by the Secretary of Health and Human Resources under Executive Order Twentyfive (98).