Virginia Regulatory Town Hall

Final Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services (12 VAC 30)
VAC Chapter Number:	Chapter 50
Regulation Title:	Amount, Duration, and Scope of Services
Action Title:	Qualifications for Community Mental Health Clinic Providers
Date:	05/16/2000

Please refer to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99) , and the *Virginia Register Form,Style and Procedure Manual* for more information and other materials required to be submitted in the final regulatory action package.

Summary

Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment; instead give a summary of the regulatory action. If applicable, generally describe the existing regulation. Do not restate the regulation or the purpose and intent of the regulation in the summary. Rather, alert the reader to all substantive matters or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. Please briefly and generally summarize any substantive changes made since the proposed action was published.

These recommended final regulations establish educational and licensing criteria for staff of Community Services Boards when the staff renders services to Medicaid recipients and seeks reimbursement from Medicaid. Once the regulations become effective, they will 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. Maintaining a consistent quality of health care without regard for source of payment, will directly improve the mental health care services Medicaid recipients receive.

Changes Made Since the Proposed Stage

Please detail any changes, other than strictly editorial changes, made to the text of the proposed regulation since its publication. Please provide citations of the sections of the proposed regulation that have been altered since the proposed stage and a statement of the purpose of each change.

12VAC30-50-180: Technical language edit in response to public comment to clarify intent.

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency: including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

The Director, acting in lieu of the Board of Medical Assistance Services, adopted these final regulations on May 15, 2000.

Basis

Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority, shall be provided. If the final text differs from that of the proposed, please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.

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 the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements. On June 3, 1999, the Director approved the initiation of a public comment period for the proposed regulations. The Code, in §9-6.14:7.1 et seq., requires agencies to adopt and amend regulations subject to public notice and comment when the action being taken does not meet one of the statutory exemptions.

42 CFR §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

Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the final regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.

The purposes of this proposal are to establish provider qualifications applicable to public community mental health clinics and 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

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement of the regulatory action's detail.

The section of the State Plan affected by this action is the Narrative for the Amount, Duration, and Scope of Services, Clinic Services (12 VAC 30-50-180).

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 frequently ask 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), 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.

Under the federal definition discussed above, clinics must be physician directed. 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.

This regulatory change targets 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 there are 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.

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 or 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 or 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.

Issues

Please provide a statement identifying the issues associated with the final regulatory action. The term "issues" means: 1) the advantages and disadvantages to the public of implementing the new provisions; 2) the 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 include a sentence to that effect.

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.

Public Comment

Please summarize all public comment received during the public comment period and provide the agency response. If no public comment was received, please include a statement indicating that fact.

DMAS' proposed regulations were published in the December 20, 1999, Virginia Register for their public comment period from December 20 through February 18, 2000. Comments were

received from six local Communities Services Boards (CSBs), the Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Professionals, the Virginia Academy of Clinical Psychologists, and the Virginia Association of Community Services Boards, Inc. DMAS also sent, on November 30, 1999, this proposed regulation to all local Community Services Boards to solicit comments. A summary of the comments received and the agency's response is attached separately. See Attachment.

Detail of Changes

Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or crosswalk - of changes implemented by the proposed regulatory action. Include citations to the specific sections of an existing regulation being amended and explain the consequences of the changes.

12VAC30-50-180: Technical language edit in response to public comment to clarify intent.

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which 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.

This regulatory action will not have any negative affects on the institution of the family or family stability. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, nor the assumption of family responsibilities. Because this regulatory action has been designed to require the improvement of the professional qualifications of professionals who render mental health therapy services, this regulatory action is expected to have a positive affect on families. It is expected to strengthen parental authority and rights in the education, nurturing, and supervision of their children, as well as strengthening the marital commitment between spouses.

SUMMARY OF PUBLIC COMMENTS RECEIVED

On

Amount, Duration, and Scope of Services: Clinic Services Provider Qualifications

On December 20, 1999, DMAS published its proposed regulations (12 VAC 30-50-180) for the Amount, Duration, and Scope of Services: Clinic Services: Provider Qualifications in the Virginia Register for their public comment period from December 20 – February 18, 2000. DMAS also sent, on November 30, 1999, this proposed regulation to all Community Services Boards to solicit comments.

Comments were received from six Community Services Boards (CSBs), the Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Professionals, the Virginia Academy of Clinical Psychologists, and the Virginia Association of Community Services Boards, Inc. A summary of the comments received and the agency's responses follow. These comments are organized by the subject since most commenters addressed the same issues.

The comment received from the Department of Health Professions Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Professionals questioned some non-specific internal reference language in subsection C3. Upon review and consideration of this comment, DMAS has modified the non-specific language to address this comment.

The comment received from the Virginia Academy of Clinical Psychologists expressed concern for the development of a two-tiered system of health care: a higher level for private paying or insured patients and a lower quality for Medicaid recipients. The Virginia Academy of Clinical Psychologists registered its strong support of the proposed regulations. DMAS appreciates this support from this professional organization.

CSBs' Enrollment as Clinic Providers

This was the most frequent comment from the CSBs as they view the physician supervision requirement, which is federally tied to their clinic provider status, as requiring an even higher level of care than that required of private sector providers. Their comments stated that whatever barriers existed should be removed so that CSBs may participate as Medicaid providers in professional categories other than the "clinic" category. The commenters further stated that they were aware of large multidisciplinary groups, e.g., the MCV Family Counseling

Center, that participate on a basis that does not require physician oversight. The CSBs stated that the clinic provider classification created higher requirements for public sector providers than for private sector providers. All of the CSB commenters stated their belief that it would be prudent for DMAS to switch the mental health clinics to independent professional providers.

One commenter stated that this proposal was not well thought out, would have adverse consequences on CSBs' abilities to deliver services as well as having significant financial and personnel consequences. This commenter did not disagree with the desire to improve the quality of care, but stated that such unilateral actions without a coordinated response from the funding agencies would have adverse impacts. While it is apparent that federal HCFA regulations do require physician directed care, there is an irony in that all the professionals listed are able to practice independently resulting in a higher clinic standard which will be more costly and more burdensome than the private sector standard. This commenter recommended that DMAS switch the CSB clinics to independent providers, if it intended to proceed with this regulatory change, thus placing these clinics on an equal footing with private practitioners. With such an action, this commenter stated the willingness to support making all-but-licensed staff subject to supervision appropriate for their respective license.

Another commenter stated that the various definitions of "physician directed" in the community treatment setting have been particularly perplexing. This commenter noted that the term is a federal requirement but that the term's definition has been subject to state interpretation.

The Virginia Association of Community Services Boards, Inc., strongly recommended that the regulations be further amended so that CSBs are no longer designated "community clinics". This commenter stated that CSBs should be considered as a 'group practice', identical to those in the private sector. Adopting the current payment method now utilized to reimburse group psychiatry practices for the CSB system as well, would result in reimbursement being sent to the organization that employs each licensed staff person rather than to each individual provider. These commenters stated that such a change would abolish the 'two-tiered' system and guarantee equal access and comparable quality of care in the private and public sectors.

Response:

CSBs are established and defined by the COV §§ 37.1-194 and 37.1-194.1, respectively. CSBs must serve mentally ill, mentally retarded, and substance abusing individuals, any and all of whom may have multiple physical ailments. Such physical ailments can require a variety of

treatments from legend drugs (only available through prescription) through and including hospitalizations (Medicaid coverage of hospital admissions requires physician certification). Licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), Psychiatric Clinical Nurse Specialists (Psy-CNS), and licensed clinical psychologists are not permitted by their licenses to prescribe drugs or admit individuals to inpatient acute care hospitals. Both of these functions are reserved by the professional licensing agency to physicians.

The Health Care Financing Administration interprets the Social Security Act and Code of Federal Regulations in the State Medicaid Manual for state Medicaid programs. Section 4320 of the State Medicaid Manual states: "Clinic services, as defined by 42 CFR 440.90, do not include services provided by hospitals to outpatients. Outpatient hospital services, which are authorized by the regulations at 42 CFR 440.20, are separate and distinct from clinic services. As defined by the regulations, clinic services must be provided by a facility that is not part of a hospital but is organized and operated (emphasis added) to provide medical care to outpatients. Thus, clinic services, in accordance with 42 CFR 440.90, must be provided by a freestanding facility, which means that the clinic may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial or other connection between the clinic and the hospital."

In their comments the CSBs compared themselves to the MCV Family Counseling Center, pointing out that this group does not have to be physician directed and arguing that they (the CSBs) were more like this group than true clinics. The MCV Family Counseling Center is an association of licensed professionals (including physicians), who practice within the constraints of their state-issued licenses, and represents an outpatient mental health service rendered under the authority of a licensed and certified hospital. These associations do not have any statutory mandate to exist or to provide certain services. For the CSBs to state that they should be treated like DMAS treats these organizations is not comparable.

CSBs are not now associations of licensed professionals nor will they be associations of licensed professionals when, after the two-year grace period established by these regulations, all CSBs must be in compliance with the regulation. After the two-year grace period, CSBs may still have unlicensed, but supervised, staff who provide clinic services to non-Medicaid eligible individuals. These unlicensed staff will also be able to perform non-psychotherapy treatment services.

A more appropriate comparison for CSBs would be to private mental health clinics, of which Medicaid has several enrolled as providers. In order to enroll as a Medicaid provider and seek reimbursement, a private mental health clinic must be physician directed (consistent with federal rules at 42 CFR 440.90) the same as a public mental health clinic (CSBs).

Enrolling the CSBs under the clinic option (regulated by 42 CFR 440.90) represents a policy decision based on a long history and tradition deriving from the CSBs statutory mandate. Historically and for purposes of Medicaid reimbursement, CSBs have operated with unlicensed personnel but with physician direction. The CSB perception that DMAS is seeking to apply more stringent requirements to its public providers than it does to its private providers is not accurate. The proposed regulations will apply a consistent requirement to the CSBs that is presently required of private mental health clinics.

The issue of changing the way CSBs are enrolled with DMAS is beyond the purview and authority of this regulatory action. Provider classification and enrollment is not regulated by the State Plan for Medical Assistance. It is indeed possible for LCSWs, LPCs, Psy-CNS, and clinical psychologists to practice independently (in the private sector) and receive Medicaid reimbursement. But since they lack prescriptive ability and admission rights to hospitals, they must associate themselves with licensed physicians so that they are prepared to care for the entire range of services which may be needed by their clients.

In arguing that this regulatory action reinforces a two-tiered system of health care because of the physician-direction requirements for clinic services, the CSBs have misconstrued the policy. DMAS does not enforce one set of rules for public providers and another for private providers. In fact, several private mental health clinics are enrolled with DMAS that are held to the same physician direction standard that is herein being proposed to be required of CSBs.

Physician Supervision/Residency

This was the next most frequent comment. Commenters indicated that being required to see the attending physician first before beginning therapy (with a therapist) caused Medicaid recipients, who were seeking mental health services from community services boards, to remain on waiting lists. Commenters indicated that this undesirable situation resulted from the lack of available professionals to manage the caseload. Another commenter indicated that CSBs have very limited amounts of psychiatric or physician time available and those 'precious hours are needed by clients with significant psychiatric difficulties'.

"The requirement for residency for physicians is broader than the community requirement for an independent physician billing for outpatient services, who may bill for

clinical services without having completed a three year residency. We can not see the justification for creating a still higher standard within the clinic than is required for independent practice elsewhere."

Another commenter stated that Medicaid recipients could choose to receive outpatient mental health services from either clinics or independent practitioners. In those instances where Medicaid recipients are provided services by non-physician professionals acting as independent practitioners without physician supervision, their care will be less comprehensive than services provided in physician directed mental health clinics. This commenter summarized the federal regulations at 42 CFR §§ 440.50, 440.90 giving emphasis to the physician supervision requirement.

This commenter further stated that "[u]nder the existing Virginia codification of the Federal requirement, outpatient psychiatric and psychological services may be and are being provided by directly enrolled non-physician providers without the physician supervision required by Federal regulation whether provided in an office or a mental health clinic. Requiring public mental health clinics to provide services by licensed psychologists, licensed clinical social workers, and licensed professional counselors under physician supervision while simultaneously permitting the same class of services to be provided in offices without physician supervision seemingly contradicts the language of the underlying federal regulations and established a two tiered system of care for medicaid [sic] patients which DMAS states it has sought to avoid. The application of physician direction to mental health clinics is contrary to the explicit language of the existing VAC".

The Virginia Association of Community Services Boards (VACSB) stated that, with this proposed regulatory change, the CSBs would now 'bear the cost of maintaining licensed staff and paying for physician coverage to provide physician supervision. The private sector avoids the cost of providing such physician supervision.' The VACSB further recommended that the two-tiered system be 'abolished by making the requirements for private sector group practices and for CSBs identical: require the use of licensed staff with no requirement for physician supervision'.

Response:

DMAS does require independent physicians who are enrolled in the DMAS program to complete a three-year residency program in psychiatry. DMAS does not reimburse general

physicians for psychiatric services if they are not also certified to practice psychiatry. They must also be enrolled with DMAS under the psychiatry subspecialty in order to be reimbursed.

The previously referenced State Medicaid Manual states: "Physician Direction Requirement.-- Regulations at 42 CFR 440.90 limit coverage of clinic services to situations in which services are furnished under the direction of a physician. As stipulated by section 1905(a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all the hours that services are provided. However, each patient's care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians, who are affiliated with the clinic, must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical and dental practice. For a physician to be affiliated with a clinic, there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement. Also, each clinic must have a medical staff which is licensed by State law to provide the medical care delivered to its patients."

Federal law has established several different services, with concomitant different basic requirements, which Title XIX (Medicaid) programs either must or may cover. Physician services (42 CFR 440.50) are mandatory services; Medical or other remedial care provided by licensed practitioners (42 CFR 440.60) are optional services; and clinic services (42 CFR 440.90) are optional.

Physician services, as defined federally, "means services furnished by a physician (i) within the scope of practice of medicine or osteopathy as defined by State law; and (ii) by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy."

Medical or other remedial care, as defined federally, "means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law."

Clinic services, as defined federally," means 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: (i) Services furnished at the clinic by or under the direction of a physician or dentist. (ii)…."

DMAS cannot modify §§ 42 CFR 440.50, 440.60, or 440.90 as these are federal regulations. DMAS must enforce the requirements for professional supervision that are established by the Health Care Financing Administration. DMAS does require licensed clinical social workers (LCSW) or licensed professional counselors (LPC) who are employed by psychiatrists (that is who work in the psychiatrists' office) to be supervised by their employing physician. In such professional arrangements, the psychiatrists are the enrolled and billing providers, not the LCSWs, LPCs, etc.

Other LCSW and LPC professionals who practice independently, without physician supervision, are directly enrolled by DMAS under the authority of 42 CFR § 440.60. That federal regulation requires that they operate within the constraints of their professional licenses, as determined by State law. LCSWs are permitted by state regulation (18 VAC 140-20-37) to function autonomously. LPCs are required by state regulation (18 VAC 115-20-130) to "[b]e aware of the areas of competence of related professions and make full use of other professional, technical and administrative resources to secure for clients the most appropriate services."

In addition, DMAS has a tiered payment methodology for mental health services which results in psychiatrists receiving 100% of the DMAS maximum payment and other professionals (psychologists, LCSWs, LPCs) receiving reduced percentages.

Finally, it is not a Medicaid or federal requirement on the CSBs that in order for a new patient to be admitted to therapy service with an employed LCSW, LPC, Psy-CNS or psychologists that he first be evaluated by a physician. This first-step-first requirement is self-imposed by the CSBs. DMAS suggests that CSBs consider developing clinical protocols. Such protocols, developed by physicians to be used by CSB staff, would determine the appropriate triaging of new patients so that only those patients needing immediate psychiatric and/or medication evaluation/prescription would be initially directed to the supervising physician.

Two-Tiered System of Health Care

Another commenter stated that the physician supervision requirements proposed in the regulation would reinforce a two-tiered system of care by requiring that licensed mental health clinic professionals be supervised by a physician while NOT requiring physician supervision of independent practitioners. This commenter further stated his belief that it was a violation of Federal law to NOT require physician supervision of psychiatric services and therefore recommended that physician supervision be required regardless of the setting (either public or private) in which the service is provided.

The Virginia Association of Community Services Boards stated that the two-tiered system of health care imposed an unfair double burden on CSBs by requiring them to "provide a higher and more costly level of care than that provided by the private sector."

Response:

As indicated above, DMAS cannot impose more stringent requirements (such as requiring physician supervision) when the federal law on the issue is limited and specific. Such a difference in requirements, while deriving from federal law, does not create or contribute to a two-tiered system of health care. This commenter was in error in the stated belief that DMAS is violating federal law in this issue. DMAS is carrying out specifically stated federal law.

DMAS is only attempting in this regulatory action to establish licensing standards for staff performing psychotherapy when Medicaid payment will be claimed. DMAS' regulatory action makes no impact on the federal physician direction requirement. Even after all CSB staff is licensed, the federal physician direction requirement of mental health clinics will remain unchanged.

Access to Services and (Negative) Fiscal Impact and Grace Period to Implement Changes

One commenter indicated that the two-year grace period permitted in the regulations would not solve the access problem. Time by itself does not provide the money nor does it result

in the termination or replacement of staff who lack the proper credentials. This commenter pointed out that no survey had been conducted of CSBs about the consequences of this change so DMAS was not in a position to state the magnitude of either the change or its costs. This commenter pointed out that there are negative issues that should be addressed, such as what to do with non-qualifying existing staff and finding the funds to address the proposed change on an ongoing basis.

The Virginia Association of Community Services Boards stated that one of the consequences of the unfair burden was that Medicaid recipients seeking behavioral health services from CSBs are inconvenienced unnecessarily because to access care they must go through one extra step (a face-to-face session with a physician) before they start outpatient psychotherapy, a step the private sector is not required to impose. "This requires public sector consumers to endure longer waiting time and increased inconvenience to access outpatient care."

"A full understanding of how the appropriation process works in the CSB system would make clear that Boards can not simply ask for money and have it appropriated. In fact, the Board's [sic] are never able to determine appropriation increases from state funds. Thus, the proposed solution to the increased costs is unrealistic and naïve." This section does acknowledge that there are increased costs.

Another commenter asked how a two-year grace period would cover the cost of something that will be ongoing after that?

Response:

DMAS recognizes that CSBs "cannot simply ask for money and have it appropriated." As in all budgeting situations, various priorities must be weighed and balanced against each other and decisions made as to recipients of appropriations as well as those requests that are not to be funded. It is beyond DMAS' purview and expertise to explain appropriation increases from state funds.

Both DMAS and DMHMRSAS believed it to be reasonable to expect that CSB executive directors would use the two-year grace period to evaluate their staff credentials, revise staff assignments, and adjust their appropriation requests. DMAS presumed that, for an ongoing expense just like for rents, phone expenses, staff salaries and the like, the CSBs would make provisions for required physician supervision costs in future budget requests. DMAS agrees that

time, by itself, does not provide the money or replace the staff lacking the proper credentials. However, time does provide for the passage of budget cycles, appropriations requests, and advertising, interviewing, and hiring new, properly credentialed staff.

And indeed, a review of the 2000 budget bill for DMHMRSAS indicates that funds have been targeted for transfer concerning psychiatrist recruitment and retention. The fund transfer will permit the combination of resources from several physician scholarship and loan programs to provide a more flexible approach to recruiting and retaining physicians, including psychiatrists, and medical students to medically underserved areas in the Commonwealth.

Consideration of this regulation has been ongoing since 1994, including a workgroup with DMHMRSAS and CSB representation and a survey of CSBs at that time. The proposed regulation represented a thorough consideration of the issues, including good clinical practice, requirements of other third-party payers and HMOs, and provision of quality care to the public. DMAS believes that CSBs can deploy their workforce to provide services within this regulation. After the two-year grace period to comply, CSBs will be able to use all licensed and licensed-eligible staff to provide clinic services.

The issue about job placement for existing non-licensed staff is recognizably an important one for the CSBs. The possibility of staff re-assignments, to serve non-Medicaid eligible clientele or Medicaid recipients who receive services other than clinic services, deserves consideration by the CSB executive directors.

All-But-Licensed Professionals

"The addition of an all-but-licensed category will expand the number of eligible providers by a small amount, but it will not deal with those providers currently in the system which can not meet this requirement. The effect of this new change will make several existing CSB employees ineligible as providers for billing under Medicaid."

Response:

DMAS understands that CSBs use all-but-licensed staff (in essence technicians) in the provision of mental health therapy services. DMAS agrees that some existing CSB employees could be rendered ineligible for billing Medicaid clinic services. Those affected employees could elect to become licensed if they desired to continue to serve Medicaid clinic service recipients. If they preferred to not become licensed, then they could serve non-Medicaid eligible recipients, since CSBs must serve all citizens who present for service regardless of their source of payment or ability to pay. They could also perform other CSB services that are not psychotherapy and do not require licensure.

Some CSBs Already Employ Only Qualified Therapists in Positions Which Provide Clinic Services

One commenter stated that the basis for this assertion was unknown and, to the degree that it is false, an important premise of this proposal is undermined.

Response:

The basis for this assertion derived from consultation with the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Since DMAS did not conduct a survey of CSBs to directly determine the extent of their employing qualified therapists, it could indeed be an erroneous premise. However, DMAS believes that the central office of the mental health agency is informed as to the staffing status of its field offices and is knowledgeable about good clinical practice.

A variety of factors, including best practices, requirements of other insurers and HMOs, and the requirements of HMOs on contract with DMAS, have resulted in many CSBs re-deploying their work force to assure that licensed staff are providing clinic services. Further, the proposed regulation also allows the CSBs to deploy "all-but-licensed staff" to provide clinic services, thereby increasing the pool of staff who can provide clinic services. Within the two-year grace period from the time the regulation is effective, many of these staff will complete their licensing requirements and be able to supervise other "all-but-licensed" staff.