townhall.virginia.gov

Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12VAC30-10-540, 12VAC30-30-10, 12VAC30-50-130, 12VAC30-60-5, 12VAC30-60-50, 12VAC30-60-61, 12VAC30-130-850, 12VAC30-130-860, 12VAC30-130-870, 12VAC30-130-880, 12VAC30-130-890; 12VAC30-130-3000, 12VAC30-130-3020
Regulation title(s)	Residential Treatment Services Emergency Regulations: Amount, Duration and Scope of Medical and Remedial Services; and Standards Established and Methods Used to Assure High Quality of Care
Action title	2016 Psychiatric Residential Treatment Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications
Date this document prepared	

This form is used when an agency wishes to promulgate an emergency regulation (to be effective for up to eighteen months), as well as publish a Notice of Intended Regulatory Action (NOIRA) to begin the process of promulgating a permanent replacement regulation. This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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

The DMAS psychiatric residential treatment service was implemented in 2001 and the associated regulations have not been updated since then. The existing regulations are not adequate to ensure successful treatment outcomes are attained for the individuals who receive high cost high intensity residential treatment services. Since moving behavioral health services to Magellan (the DMAS Behavioral Health Service Administrator, or BHSA) there has been enhanced supervision of these services. The enhanced supervision has led to an increased awareness of some safety challenges and administrative challenges in this high level of care. The proposed revisions will serve to better clarify policy interpretations that revise program standards to allow for more evidence based service delivery, allow DMAS to implement more effective utilization management in collaboration with the BHSA, enhance individualized coordination of care, implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, and support DMAS audit practices. The changes will move toward a service model that will reduce lengths of stay for and facilitate an evidence based treatment approach to better support the individual's discharge into their home environment.

The emergency stage action includes changes to the following areas: (i) provider qualifications including acceptable licensing standards; (ii) pre-admission assessment requirements, (iii) program requirements, (iv) new discharge planning and care coordination requirements and; (iv) language enhancements for utilization review requirements to clarify program requirements and help providers avoid payment retractions. These changes are part of a review of the services to ensure that they are effectively delivered and utilized for individuals who meet the medical necessity criteria. For each individual seeking residential treatment their treatment needs will be assessed with enhanced requirements by the current Independent Certification Teams who must coordinate clinical assessment information and assess local resources for each person requesting residential care to determine an appropriate level of care. The certification teams will also be more able to coordinate referrals for care to determine, in accordance with DOJ requirements, whether or not the individual seeking services can be safely served using community based services in the least restrictive setting. Independent Team Certifications will be conducted prior to the onset of specified services, as required by CMS guidelines, by the DMAS Behavioral Health Services Administrator.

The proposal includes changes to program requirements that ensure effective levels of care coordination and discharge planning occurs for each individual during their residential stay by enhancing program rules and utilization management principles that facilitate effective discharge planning and establish community-based services prior to the individual's discharge from residential care. The proposal requires enhanced care coordination to provide the necessary, objective evaluations of treatment progress and to facilitate evidence based practices during the treatment to reduce the length of stay by ensuring that medical necessity indicates the correct level of care and that appropriate and effective care is delivered in a person centered manner. The proposal requires that service providers and local systems will use standardized preadmission and discharge processes to ensure effective services are delivered.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

BHA = Behavioral Health Authority
BHSA = Behavioral Health Services Administrator
CMS = Centers for Medicare and Medicaid Services
CSA = Comprehensive Services Act
CSB = Community Services Board
DBHDS = Department of Behavioral Health and Developmental Services
DMAS = Department of Medical Assistance Services
DOJ = Department of Justice
EPSDT = Early Periodic Screening, Diagnosis, and Treatment
FAPT = Family Assessment and Planning Team
FFP = Federal Financial Participation
FFS = Fee for Service
ICF/ID = Intermediate Care Facility for the Intellectually Disabled
ICF/MR = Intermediate Care Facility for the Mentally Retarded
IMD = Institution for Mental Disease
MCO = Managed Care Organization
MDT = Multi-Disciplinary Treatment Team

Emergency Authority

The APA (Code of Virginia § 2.2-4011) states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of subdivision A. 4. of § 2.2-4006. Please explain why this is an emergency situation as described above, and provide specific citations to the Code of Virginia or the Appropriation Act, if applicable.

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

The agency is proposing this regulatory action to comply with Chapter 665 Item 301.PP of the 2015 *Acts of Assembly* which states:

"The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department

shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."

In addition, the agency is complying with the 2015 Acts of Assembly, Chapter 665, Item 301.OO (c) (7), (8), (9), (14), (15), (16), (17), and (18) which state that DMAS shall develop a blueprint for a care coordination model for individuals in need of behavioral health services that includes the following principles:

"7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.

8. Builds upon current best practices in the delivery of behavioral health services.

9. Accounts for local services and reflects familiarity with the community where services are provided.

…

14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.

15. Simplifies the administration of acute psychiatric, community and mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers."

In response to item 301.OO(c)(14), DMAS is proposing new requirements to ensure that comprehensive discharge planning begins at admission to a therapeutic group home or residential treatment facility so that the individual can return to the community setting with appropriate supports at the soonest possible time.

DMAS is responding to the legislative mandates in 301.OO(c) 7-9 and 14-15 by sunsetting the VICAP regulation at 12VAC30-130-3020. The VICAP program is no longer needed, as the BHSA is now conducting thorough reviews of medical necessity for each requested service, and the funds allocated to the VICAP program can be more effectively used elsewhere.

DMAS is responding to the legislative mandates in 301.OO(c) 16-18 by creating a single point of contact at the BHSA for families and caregivers that will increase timely access to residential behavioral health services, promote effective service delivery, and decrease wait times for

medical necessity and placement decisions that previously have been managed by local FAPT teams. The FAPT teams are not DMAS enrolled service providers, and the individuals who must use the FAPT process to gain access to Medicaid covered residential treatment are not subject to the established Medicaid grievance process and choice options as mandated by CMS. The enhanced interaction of the families and the BHSA will enable more thorough data collection to ensure freedom of choice in service providers, and to measure locality trends, service provider trends, and population trends to facilitate evidence based decisions in both the clinical service delivery and administration of the program. The enhanced family interaction will enable the BHSA to complete individual family surveys, and monitor care more effectively after discharge from services to assess the family and individual perspective on service delivery and enable DMAS to more effectively manage evidence based residential treatment services.

In addition, the agency is complying with the 2015 Acts of Assembly, Chapter 665, Item 301.OO (d), which states:

"The department may seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model … This model may be applied to individuals on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

Since 2001, when residential treatment services were implemented by DMAS, individuals have not had access to standardized methods of effective care coordination upon entry into residential treatment due to locality influence and DMAS reimbursement limitations. This has resulted in a fragmented coordination approach for these individuals who are at risk for high levels care and remain at risk of repeated placements at this level of care. The residential treatment prior authorization and utilization management structures require an enhanced care coordination model to support the individuals who receive this level of service to ensure an effective return to the family or caregiver home environment with follow up services to facilitate ongoing treatment progress in the least restrictive environment. The added coordination is required to navigate a very complex service environment for the individual as they return to a community setting to establish an effective aftercare environment that involves service providers who may be contracted with a variety of entities such as DMAS contracted MCO's, BHSA enrolled providers, the local FAPT team, local school divisions and the local CSB. This regulation will allow DMAS to implement a contracted care coordination team which will focus on attaining specific clinical outcomes for all residential care episodes and to provide a new single liaison that will ensure coordination of care in a complex service environment for individuals upon discharge from residential treatment and prior to the time when they will enroll in an MCO. (During this transition period the individual is very vulnerable to repeated admissions to residential or inpatient care and must also be supported in the FFS environment with resources from the local CSB, BHSA enrolled services providers and requires ongoing support and coordination with the local FAPT team to provide aftercare services consisting of post discharge follow up and transition services provided by the BHSA coordination team.)

The care coordination team will:

a. Provide increased standardization of pre-admission assessment activity,

b. Provide facilitation of an effective independent certification team process,
c. Ensure that MCO and medical home resources are used to provide accurate psychosocial assessment and clinical/medical history to the certification team and BHSA,
d. Facilitate accurate authorization decisions and consider community-based service options prior to any out-of-home placement,
e. Facilitate high levels of family involvement,
f. Provide aggressive discharge planning that ensures smooth transition into community-based services and MCO-funded health services, and
g. Provide meaningful, coordinated post-discharge follow-up for up to 90 days post discharge with the youth and family.

The residential care coordination team will ensure meaningful communication across all parts of the CSA, DBHDS, MCO and FFS service systems to maximize efficiency of activities, eliminate duplicative and/or conflicting efforts, and ensure established timelines are met (e.g., regular assessment of progress).

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

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

"(b) Assesses the quality of those services;

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

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

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

The Governor is hereby requested to approve this agency's adoption of these emergency regulations entitled "2015 Psychiatric Residential Treatment Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications" and also authorize the initiation of the promulgation process provided for in § 2.2-4007.

Legal basis

Other than the emergency authority described above, 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) the promulgating entity, i.e., agency, board, or person.

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

The agency is proposing this regulatory action to comply with Chapter 665 Item 301.OO and PP of the 2015 Acts of Assembly as discussed above.

Purpose

Please describe the subject matter and intent of the planned regulatory action. Also include a brief explanation of the need for and the goals of the new or amended regulation.

This regulatory action is essential to protect the health, safety, or welfare of individuals with Medicaid who require behavioral health services. In addition, these proposed changes are intended to promote improved quality of Medicaid-covered behavioral health services provided to individuals.

This regulatory action is also essential to ensure that Medicaid individuals and their families are well informed about their behavioral health condition and service options prior to receiving these services. This ensures the services are medically necessary for the individual and are rendered by providers who use evidence based treatment approaches.

While residential treatment is not a service that should be approved with great frequency for a large number of individuals it is a service that should be accessible to the families and individuals who require that level of care. The current service model has significant operational layers that must be navigated to access residential services. The current program processes involve coordination of care by local FAPT teams who have, over time, demonstrated some influence on determining an individual's eligibility for FAPT funded services. The local influence on the programs administration causes limitations on individualized freedom of provider choice and inconsistent authorization of funding for persons deemed to need psychiatric care out of the home setting. This local administration of the primary referral source for residential treatment lies outside the purview of DMAS and this situation produces outcomes that are inadequate to meet CMS requirements on ensuring the individual freedom of choice of providers. In addition, local FAPT administrators do not enforce the Department of Justice (DOJ) settlement requirements in a uniform manner.

DMAS has add content to program requirements and covered services portions of the regulations to better clarify the benefit coverage and utilization criteria. The emergency regulations allow

the use of additional information collection to better assess ways to reduce the average length of stay for individuals in residential care, and to better coordinate educational funding for those who require medically necessary services in a psychiatric treatment setting by using enhanced Medicaid supports.

DMAS' goal is that individuals receive the correct level of service at the correct time for the treatment (service) needs related to the individual's medical/psychiatric condition. Residential Treatment services consist of behavioral health interventions and are intended to provide high intensity clinical treatment that should be provided for a short duration. Stakeholders' feedback supported DMAS' observations of lengthy durations of stay for many individuals. Residential treatment services will benefit from clarification of the service definition and eligibility requirements, to ensure that residential treatment does not evolve into a long term level of support instead of the high intensity psychiatric treatment modality that defines this level of care.

Need

Please describe the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, delineate any potential issues that may need to be addressed as the regulation is developed.

DMAS needs to implement new regulations to update provider licensing and accreditation standards, increase care coordination, and address quality management deficiencies noted during provider audits and quality management functions. The new program requirements will also begin the process of further assessing program needs, correcting deficient independent certification team practices that result in delayed access to care and occasional interference in the access to freedom of choice for individuals when selecting treatment providers The regulation package will also facilitate a new workflow that will allow further assessment of service trends and locality variations in service delivery and discharge planning to assess program trends.

Substance

Please describe any changes that are proposed. Please outline new substantive provisions, all substantive changes to existing sections, or both where appropriate. Set forth the specific reasons the agency has determined that the proposed regulatory action is essential to protect the healthy, safety, or welfare of Virginians.

The sections of the State Plan for Medical Assistance that are affected by this action are: Inspection of Care in Intermediate Care Facilities (12VAC30-10-540), Mandatory Coverage: Categorically Needy and other required special groups (12VAC30-30-10), the Amount, Duration, and Scope of Medical and Remedial Services Provided to Categorically/Medically Needy Individuals-EPSDT Services (12 VAC 30-50-130); Applicability of utilization review requirements (12VAC30-60-5), Utilization control: Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD) (12VAC30-60-50) and Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children (12VAC30-60-61). The state-only regulations

that are affected by this action are Residential Psychiatric Treatment for Children and Adolescents (plans of care; review of plans of care (12VAC30-130-850 through 130-890).

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, and likely impact of proposed requirements
12VAC30-10-540		Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals under 21, and Mental Hospitals	Terminology change to transition from using the term "the mentally retarded" to using the term "persons with intellectual disabilities".
12 VAC 30-50-130		EPSDT services provides for inpatient psychiatric services for individuals younger than 21 years of age and sets out the licensing/accreditation requirements that must be met by the defined Inpatient Psychiatric Facilities.	New text includes significantly more detail regarding covered services, incorporations of repealed regulatory text from 12VAC30-130-850-890, EPSDT criteria, independent certification team provider requirements and required activities, admission practices, plan of care requirements, new definitions, changes to service names, elimination of Level A service, enhanced program requirements, care coordination and discharge planning requirements.
12VAC30-60-5		Applicability of utilization review requirements	Deleted the term "unless otherwise specified" to better clarify documentation requirements.
12 VAC 30-60-50		Utilization control: Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Persons with Intellectual Disablity (ICF/ID) and Institutions for Mental Disease (IMD).	Added term "Persons with Intellectual Disability (ICF/ID", added definition for Institution for Mental Disease, or "IMD" changed the term ICF/MR to ICF/ID where possible and added quality assurance requirements for the pre admission diagnosis and the independent certification team, referenced the reporting requirements for serious incidents and restraints
12VAC30-60-61		Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children.	New text includes service requirements, provider requirements and required activities, incorporations of repealed regulatory text from 12VAC30-130-850-890, EPSDT criteria, changes to terminology to replace ISP with CIPOC, admission and intake requirements, plan of care requirements, new definitions, changes to service names, elimination of Level A service, enhanced program requirements, care coordination and discharge planning requirements. referenced the reporting requirements for serious incidents and restraints
12VAC 30-		REPEALED	Moved content to other regulatory

130-850 through 890			sections.
12VAC 30-130-3000		Includes language referring to Level A and B group homes.	Updated language to therapeutic group homes and now also includes psychiatric residential treatment facilities.
12VAC 30-130-3020		Requires an independent clinical assessment for Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services for individuals under 21 years old.	Sunsets the independent clinical assessment at the time this emergency regulation is promulgated.

Alternatives

Please describe all viable alternatives to the proposed regulatory action that have been or will be considered to meet the essential purpose of the action. Also describe the process by which the agency has considered or will consider other alternatives for achieving the need in the most cost-effective manner.

These changes are required by the 2015 Acts of Assembly, Item 301.OO and PP, and there are no other methods that will satisfy this statutory mandate.

Public participation

Please indicate whether the agency is seeking comments on the intended regulatory action, to include ideas to assist the agency in the development of the proposal and the costs and benefits of the alternatives stated in this notice or other alternatives. Also, indicate whether a public meeting is to be held to receive comments. Please also indicate whether a Regulatory Advisory Panel or a Negotiated Rulemaking Panel has been used in the development of the emergency regulation and whether it will also be used in the development of the permanent regulation.

The agency is seeking comments on this regulatory action, including but not limited to: ideas to be considered in the development of this proposal, the costs and benefits of the alternatives stated in this background document or other alternatives, and the potential impacts of the regulation.

The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: projected reporting, recordkeeping, and other administrative costs; the probable effect of the regulation on affected small businesses; and the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (**http://www.townhall.virginia.gov**), or by mail, email, or fax to Brian Campbell, Senior Policy Analyst, DMAS, 600 E. Broad Street, Richmond VA 23219, 804-225-4272 or brian.campbell@dmas.virginia.gov. Written comments must include the name and address of

the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Family Impact

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

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