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Fast-Track Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES	
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC30-50-130; 12 VAC 30-60-61; 12VAC30-50-226; 12VAC30-60-143	
VAC Chapter title(s)	Skilled nursing facility services, EPSDT, including school health services and family planning Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health and behavioral therapy services for children Community mental health services Mental health services utilization criteria; definitions	
Action title	Changing from Service-Specific Provider Intake to Comprehensive Needs Assessment	
Date this document prepared	August 3, 2020	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code.*

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

An individual may receive a DMAS community mental health service only after a Medicaid provider has gathered information about the individual's health status. In the past, providers were required to conduct a separate service-specific provider intake (SSPI) for each community

mental health service, even if the same provider offered more than one service. This regulatory package changes the SSPI to a comprehensive needs assessment (CNA). The CNA will be used by providers to screen individuals for any service offered by a provider. Allowing one CNA in place of multiple SSPIs is intended to support member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

CNA = Comprehensive Needs Assessment
DMAS = Department of Medical Assistance Services
SSPI = Service Specific Provider Intake

Statement of Final Agency Action

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

I hereby approve the foregoing Regulatory Review Summary entitled "Changing from Service-Specific Provider Intake to Comprehensive Needs Assessment" and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

8/3/2020
Date

/signature/
Karen Kimsey, Director
Dept. of Medical Assistance Services

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

As required by Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track process.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

These regulations are expected to be non-controversial because they are implementing changes that were announced in a Medicaid Memo released on November 20, 2018, and that took effect on January 1, 2019. Providers subject to these changes have not submitted comments or complaints about the changes, and have smoothly transitioned from the SSPI to the CNA.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

This regulatory action is essential to protect the health, safety, or welfare of citizens in that it supports member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

In the past, providers of community mental health services were required to conduct a separate SSPI for each community mental health service, even if the same provider offered more than one service. This regulatory package changes the SSPI to a CNA. The CNA will be used by providers to screen individuals for any service offered by a provider. Allowing one CNA in place of multiple SSPIs is intended to support member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

There is no fiscal impact to the state or the agency as a result of this change, as CMHRS services are, as of 2019, covered by managed care organizations, and the change in the number of assessments will not affect the managed care capitation rate.

Providers will no longer be permitted to bill for multiple assessments, but it is expected that any potential revenue loss related to this change will be made up by billing for service delivery, as individuals will move more quickly into community mental health services when the requirement for multiple assessments is removed.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantage to the public, the agency, and the Commonwealth is that the CNA supports member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

The primary disadvantage to Medicaid providers who offer more than one service is that they cannot bill for a separate intake for each community mental health service. Instead, one comprehensive needs assessment is used to determine which of the services offered by the provider may be needed by the individual.

However, this is not likely to cause a decrease in the provider's total billing, because providers will initiate care more quickly, and the billing that might have come from an additional assessment is likely to be replaced by billing from service provision.

In addition, individual treatment will not differ due to these changes. Even under the old SSPI process, providers can re-assess 'individuals progress and needs and can bill for that using the billing code for the service.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and 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 specific statement to that effect.

There are no requirements in this regulation that are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "Particularly affected" are those that are likely to bear any identified disproportionate material impact

which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected: None. DBHDS was involved in discussions about the move from SSPI to CNA and is in agreement with the change.

Localities Particularly Affected: None.

Other Entities Particularly Affected: None.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	Starting in 2018, CMHRS services moved into managed care networks. DMAS pays managed care organizations a capitation rate for providing these services, and that capitation rate will not be adjusted based on the change from SSPIs to CNAs. Therefore, there is no fiscal impact to the agency.
For other state agencies: projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	None
For all agencies: Benefits the regulatory change is designed to produce.	This regulatory change supports member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	None
Benefits the regulatory change is designed to produce.	This regulatory change supports member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Community mental health service providers.
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	762 unique CMHRS providers
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	There are no projected costs for affected individuals, businesses, or other entities.
Benefits the regulatory change is designed to produce.	This regulatory change supports member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. 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 regulatory change.

No alternatives would correct the regulatory language related to SSPIs to support member access to care and efficiency by reducing the time and administrative burden on providers and members they serve.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, 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) establishing less stringent compliance or reporting

requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing 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 regulatory change.

This regulatory action may have an effect on small businesses. Some community mental health providers offer more than one service, and would be required to bill only one CNA, rather than an SSPI for each service.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

As required by § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please also indicate the nature of, and reason for, your objection to using this process.

DMAS is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Emily McClellan, 600 E. Broad Street, Richmond, VA 23219; 804-371-4300, or emily.mcclellan@dmas.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the proposed regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
All			The terms “child”, “adolescent” and “individual” were removed and replaced with “youth” throughout these regulations as a more person-centered term. In addition, LMHP-Rs, RPs, and Ss were added to each reference to an LMHP. These text changes reflect current practice, and are not a change, but a correction to previous inadvertent omissions.
12 VAC 30-50-130 B 2			References to physicals and immunizations are removed because they are not relevant here.
12 VAC 30-50-130 C 1			The term “adolescent” was removed. A new definition of “comprehensive needs assessment” was added. The term “human services field” was removed because it no longer appears in this regulation. The terms QMHP-C, QMHP-E, and QPPMH now refer to definitions in the Code and in DBHDS regulations. References to “service specific provider intake” was removed. The term “youth” was added.
12VAC30-50-130 C 2 b and 3b			Language related to SSPIs was replaced with language related to CNAs.
12VAC30-50-130 D 1			The following new terms have been added: ADL Restoration, ADL supervisor, and ADL technician. The term “combined treatment services” is no longer used and has been removed. The phrase “and possibly intensive” has been removed from the definition of “discharge planning” because it is not clear. The term “emergency admissions” only applies to youth in the custody of social services, and this term was updated to clarify that.

			The terms “emergency services” and “individual” are no longer used and have been removed. The term “individual and group therapy” has been removed and replaced with the term “psychotherapy or therapy” so that this term aligns more closely with terms used by the Board of Counseling. The term “intervention” was updated to match the CMS-approved definition of this term. The term “services provided under arrangement” is no longer used and has been removed. The term “therapeutic services” was added. The term “treatment planning” was updated to match the CMS-approved definition of this term. The term “youth” was added.
12 VAC 30-50-130 D 2 a			Therapeutic group home services were updated to match the CMS-approved description of the service.
12 VAC 30-50-130 D 2 b			The therapeutic group home section was re-organized for clarity. The items now included in paragraph b came from two different locations in the old version of the regulations. (The plan of care information was moved to the clinical activities section.)
12 VAC 30-50-130 D 2 c 2 (a)			LMHP-Rs, RPs, and Ss were inadvertently left out of prior versions of this text, and were added here.
12 VAC 30-50-130 D 2 c 2 (d)			The phrase “sometimes intensive” services was removed because it wasn’t clear.
12 VAC 30-50-130 D 2 c 2 (f)			Discharge planning was removed because it duplicates information contained in the clinical activities section.
12 VAC 30-50-130 D 2 c 3 (c)			The last sentence is shortened and clarified.

12 VAC 30-50-130 D 2 c 3 (e)			The term “combined treatment” is updated to “daily therapeutic”. In addition, some content was moved from this paragraph to paragraph D 2 a and some content was deleted because it duplicates text in the clinical activities section.
12 VAC 30-50-130 D 2 c 3 (f)			A new paragraph was added related to family or support system involvement to clarify these requirements, which had been included in the previous paragraph.
12 VAC 30-50-130 D 2 d 7			This text was moved here from a prior paragraph.
12 VAC 30-50-130 D 2 d 8			The term “behavioral health” usually includes substance use disorder, so this was changed to “mental health.”
12 VAC 30-50-130 D 2 d 9			This text was moved here from a prior paragraph.
12 VAC 30-50-130 D 2 d 10 through 13			The phrase ‘in accordance with progress note “requirements”’ was changed to ‘in accordance with the definition of the term progress note.’ Sentences were restructured for clarity. References to DMAS contractors were added.
12 VAC 30-50-130 D 2 d 15			The sentence related to permission to share treatment information is deleted, as this is already required by HIPAA.
12 VAC 30-50-130 D 2 e			Licensure, staffing requirements, and documentation of care coordination, and failure to perform were moved to prior paragraphs and are deleted here.
12 VAC 30-50-130 D 3 d and e			These requirements have been removed by CMS, and are being deleted.
12 VAC 30-50-130 D 3 e			24-hour onsite nursing is changed to 24-hour onsite nursing availability. This is consistent with D3 f 2 (c)
12 VAC 30-50-130 D 3 f 2 (c)			The sentence about school contact is not relevant and was deleted.

12 VAC 30-50-130 D 3 f 2 (d)			Urine drug screens were moved to the required activities section.
12 VAC 30-50-130 D 3 g 6 through 8			Reference to progress notes was added.
12 VAC 30-50-130 D 3 g 11			References to DMAS contractors were added.
12 VAC 30-50-130 D 3 g 12			The sentence related to permission to share treatment information is deleted, as this is already required by HIPAA.
12 VAC 30-50-130 D 4 f			This change was required because treatment providers can now certify admissions when a youth transfers from different levels of care, and this statement contradicted that.
12 VAC 30-50-130 D 4 n			This change updates the regulations to match current practice.
12 VAC 30-50-130 D 5 d (1)			This change updates the regulations to match current practice.
12 VAC 30-50-130 D 6 a			Clarifies that UAI forms are required only if they have been updated since the last service authorization request.
12 VAC 30-50-130 D 8 e and f			These requirements have been removed by CMS, and are being deleted.
12 VAC 30-50-130 I 1			The term “individual” is replaced with “youth.”
12 VAC 30-50-130 I 3 and 3 (a)			The term “service specific provider intake” is updated to “behavioral therapy assessment.”
12 VAC 30-50-226 A			A new definition of “certified prescreener assessment” was added. A new definition of “comprehensive needs assessment” was added. The last sentence of the definitions of LMHP-R, RP, and S was removed because these requirements are already in place with the Dept. of Health

			Professions Board that regulate these practitioners. QMHP-A, C, and E definitions are updated to refer to the Code of Virginia. The definition of "service specific provider intake" was removed.
12 VAC 30-50-226 B			References to LMHP-R, RP, and S were inadvertently omitted from this text and have been added.
12 VAC 30-50-226 B 1 d			References to LMHP, R, RP, and S were added and references to physicians and other practitioners were deleted in accordance with existing practice.
12 VAC 30-50-226 B 3			Crisis intervention may be provided after a CNA or after a certified prescreener assessment. This is not a change in practice, but conforms the regulation to current practice.
12 VAC 30-50-226 B 6 c (6)			This is a reference to the Virginia Independent Clinical Assessment (VICAP) that is out of date. The VICAP regulations have been repealed.
12 VAC 30-60-61 A			A new definition of "comprehensive needs assessment" was added. "Failed" services was changed to "unsuccessful" services. The term "individual" was removed. The term "new service" is no longer used and has been removed. The definition of "service specific provider intake" was removed. The term "youth" was added.
12 VAC 30-60-61 B			New text in paragraphs 4, 5, and 6, was copied from 12 VAC 30-60-143 B 1, 2, and 3 for consistency across services.
12 VAC 30-60-61 C 3			Language about SSPIs was replaced with language about CNAs.
12 VAC 30-60-61 C 14			The last sentence was removed because it does not relate to ISPs.

12 VAC 30-60-61 D 4			LMHP-Rs, RPs, and Ss were inadvertently left out of prior versions of this text, and were added here.
12 VAC 30-60-61 D 13			Paragraph relating to SSPIs was deleted.
12 VAC 30-60-61 F 4, 6, 9(b), 9(c)			The term SSPI was updated to "behavioral therapy assessment."
12 VAC 30-60-143 A			The term "child or adolescent" was removed. Definitions were added for "certified prescreener," "certified prescrener assessment," and "comprehensive needs assessment."
12 VAC 30-60-143 B 7 (a) through (i)			Requirements related to comprehensive needs assessments were added.
12 VAC 30-60-143 B 8			ISP requirement was clarified. This requirement has been in place, but is stated here to keep the ISP requirements in one place.
12 VAC 30-60-143 B 8, B 8 (a) and B 8 (b)			List of qualified personnel is replaced with "appropriate professional for the service" in order to allow for staff requirements contained in later 30-60-143 sections.
12 VAC 30-60-143 B 9			Requirement related to services was added for consistency. This is not a new requirement.
12 VAC 30-60-143 I 18			Additional units authorized if medically necessary to comply with mental health parity rules.
12 VAC 30-60-143 I 19 (a) and (g)			References to Level A, B, and C facilities are out of date and have been removed.