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Proposed Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) citation(s)	12 VAC35-105
Regulation title(s)	Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	Allowing a grace period for documentation of ISPs
Date this document prepared	July 18, 2019

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 (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations.*

Brief Summary

Please 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.

This regulatory action to amend Chapter 105 ("Licensing Regulations") pertains to when a quarterly review of an individualized services plan (ISP) must be documented. It is intended to resolve misalignment between DBHDS and DMAS regulations concerning the documentation of quarterly reviews of ISPs by allowing practitioners to follow the same process rather than two different processes. For example, in DMAS regulation 12VAC30-50-226 Community mental health services, the definition of "Review of ISP" contains a corresponding 15-day grace period. Also, a grace period has existed since at least 1998 in 12VAC30-60-143 (previously subsection 140) Community mental health services.

These amendments will relieve an unnecessary administrative burden in which service providers currently must adhere to two separate regulations for the same practice. The current Licensing Regulations will be amended as follows*:

12VAC35-105-675. Reassessments and ISP reviews.

A. Reassessments shall be completed at least annually and when there is a need based on the medical, psychiatric, or behavioral status of the individual.

B. The provider shall: (i) update the ISP at least annually; and ~~. The provider shall~~ (ii) complete quarterly ~~review~~ reviews of the ISP. The provider shall review the ISP at least every three months from the date of the implementation of the comprehensive ISP ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~. These reviews shall evaluate the individual's progress toward meeting the ~~plan's~~ ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.

***Note:** It is relevant in reviewing this action to be aware of the changes to Section 675 in Regulatory Action 5040, and in general to see sections 645 – 665 for Chapter 105 for a broader view of language related to ISPs.

The DBHDS regulatory action 5091 filed on July 16, 2018, received 10 comments from CSBs during the public comment period that ended on March 6, 2019. The comments related to the need to separate case management from the 15-day language.

The State Board of BHDS subsequently concurred with staff's recommendation to shift to the standard regulatory process. This occurred on March 14, 2019. The State Board voted on the revised language for the standard process on July 17, 2019. The fast track action now counts as the NOIRA for this standard action.

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.

CSBs – Community services boards.
DBHDS – Department of Behavioral Health and Developmental Services.
DMAS – Department of Medical Assistance Services.
ISP – Individualized services plan.
State Board – State Board of Behavioral Health and Developmental Services.

Mandate and Impetus

Please 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, board decision, etc.). 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."

There is no mandate for this regulatory action. It came at the request of community services boards (CSBs) through the Virginia Association of Community Services Boards (VACSB) in April 2018.

Legal Basis

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

Sections 37.2-203 of the Code of Virginia authorize the State Board to adopt regulations that may be necessary to carry out the provisions of Title 37.2 and other laws of the Commonwealth administered by the commissioner and the department. This action was approved at the July 17, 2019, meeting of the State Board.

Purpose

Please 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.

DBHDS and DMAS regulations concerning reviews of individual service plans are not aligned. This creates an unnecessary situation in which service providers must adhere to two separate regulations for the same practice. The proposed change will align DBHDS and DMAS regulations as to when the quarterly review of the ISP must be documented, thus allowing practitioners to follow the same process rather than two different processes. This will decrease administrative burdens and allow more time to provide services.

Substance

Please 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.

Providers licensed by DBHDS are currently required to review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. There is no allowance for additional administrative time to document the review, as is allowed in DMAS regulations. Such administrative 'grace periods' are not uncommon.

By amending the current Licensing Regulations at the end of Subsection B of 12VAC35-105-675 through this action, providers will be allowed to provide documentation of each quarterly review or a revised assessment in the individual's record '*no later than 15 calendar days from the date the review was due to be completed*.' These amendments will not change the current quarterly deadline for the review. Also, clarification is made to exclude case management from this 15-day change, and specific language is added regarding 30 days related to case management. This was in response to comments received, as listed below.

Issues

Please 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.

There are no identified disadvantages to the public or the Commonwealth in making this change. The advantage for the system will be that providers have more efficient use of time because the regulations will no longer be duplicative in conflicting ways.

Requirements More Restrictive than Federal

Please 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.

This requirement is no more restrictive than applicable federal standards.

Agencies, Localities, and Other Entities Particularly Affected

Please 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.

No agency, locality, or entity is particularly affected.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, please 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. Please 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	There is no projected impact on DBHDS resulting from this regulatory change.
For other state agencies: projected costs, savings, fees or revenues resulting from the	There is no projected impact on other state agencies resulting from this regulatory change.

regulatory change, including a delineation of one-time versus on-going expenditures.	
For all agencies: Benefits the regulatory change is designed to produce.	This regulatory change is not designed to benefit any state agency.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	There is no additional cost to implement and enforce these amendments. It is expected to save staff time in CSBs, which are entities of local government.
Benefits the regulatory change is designed to produce.	It is expected to decrease administrative burdens on CSB practitioners and allow more time to provide services.

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.	Individuals receiving or needing services and their families, and providers licensed by DBHDS.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: 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.	It is not possible to estimate the exact number of individuals receiving services that will be affected by this regulation. Please see Table 2 in Report Document 552 (2017). However, at least 100,000 would be affected. Currently, DBHDS licenses approximately 1,100 service providers. There is no way to estimate the number of small businesses within the pool of all providers.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please 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 is no additional administrative cost for individuals, businesses, or other entities.
Benefits the regulatory change is designed to produce.	Providers will be alleviated of an unnecessary burden and will have more time to devote to the provision of services.

Alternatives

Please 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.

There is no other alternative to the regulatory action.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) 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.

There is no other alternative to the regulatory action. This will be a less stringent and simplified requirement for compliance reporting requirements, schedules, and deadlines. There is no establishment of performance standards for small businesses, nor any relation to exemptions for small businesses.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, please indicate whether the regulatory change meets the criteria set out in Executive Order 14 (as amended, July 16, 2018), e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable.

In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, include a discussion of the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation from the public; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation.

This action is not the result of a periodic or small business impact review.

1) There is still a need for this regulation because it provides specific standards for licensing of organizations and facilities that provide behavioral health and developmental disability services.

2) The nature of the 10 complaints or comments received from the public concerning the regulation as submitted in the fast track process had to do with the conflict of requiring case managers to document their quarterly review on the same date as all other providers. If a case manager's review is due on the same day as reviews by an individual's other providers (15 calendar days from the date review is due), commenters stated that it is likely that the other provider reviews will not be received by the case manager until the fifteenth day which would not allow the case manager the opportunity to review the documentation in a timely manner in order to complete their review thoroughly. Having

different dates allows time for case managers to complete a quality assessment based on the reviews received by the individual's other providers. This will allow case managers the opportunity to review and synthesize information from other providers into their review and their updates to the ISP, a key requirement of this service and an expectation for case managers assisting individuals. The nine comments submitted through Town Hall can be viewed here.

3) The complexity of Chapter 105 can be described as follows:
   a) To clearly articulate adequate health, safety, care and treatment requirements to assure that individuals receive safe and protected behavioral health and developmental disability services that are appropriate to their needs and levels of functioning.
   b) To clearly articulate Department procedures and actions necessary to implement regulatory requirements with the least possible cost, intrusiveness to consumers, families, and provider organizations.
   c) To provide clear and precise criteria for (a) determining mental health, developmental disability, and substance abuse program accountability and, program compliance with regulatory requirements, and (b) taking actions to enforce compliance.

4) The regulation does not overlap, duplicate, or conflict with federal or state law or regulation.

5) A periodic review of Chapter 105 was conducted 10/30/2017 - 12/15/2017. The system changed notably since the last periodic review due to the requirements of the Settlement Agreement between the United States Department of Justice and Virginia (*United States of America v. Commonwealth of Virginia*, Civil Action No. 3:12cv059-JAG) ("Settlement Agreement").

Public Comment

Please summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Ensure to include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency or board. If no comment was received, enter a specific statement to that effect.

Commenter Name	Comments	Response
Lisa Snider	We strongly oppose the change as written. DBHDS indicates the proposed changes are to align the ISP Quarterly Review Dates with DMAS regulations. While the attempt to align requirements is appreciated, this proposed change is not in line with the established processes and DMAS requirements for Developmental Support Coordination (Case Management) and Mental Health Case Management. The current requirement for completing the Case Management/Support Coordination Quarterly is 30 days from the date the Quarterly Review Period ended. This timing in critical for Support Coordinators/Case Managers to complete the requirements of their job and ensure ability to review services provided to individuals. Further, this is	**Because of the similarity of comments, the following is the DBHDS response to all citizens who provided comments:** Thank you for your comment. Following the public comment period for the Fast-Track regulatory action, this action was shifted to the standard rulemaking process. The language has been amended during the proposed stage to state documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.

Commenter Name	Comments	Response
	critically important for Support Coordinators to meet the expectations for oversight of services as indicated in the DOJ settlement agreement. Other providers must submit their quarterlies to the Support Coordinator so the Support Coordinator can review how all services are going for the individual. Further, the Support Coordination/Case management review of providers' Quarterly ISP reviews helps to identify risks so they can be addressed. It is suggested the regulation be changed to be effective for all services *except Case Management Services*. Then adding the following requirement for Case Management: Case Management services must complete the Review documentation and add to the individual's record no later than 30 calendar days from the date the review period ended.	The revised language is expected to come to the State Board for initiation of the proposed stage of the standard regulatory process. The previous fast track action counts as the Notice of Intended Regulation.
(no name listed)	We are concerned that "the 15 calendar day from the date the review is due" does not align with current DMAS regs which allows a 10 day grace period for providers and a 30 day grace period for Case Managers. The preference is for the Office of Licensing to align with the DMAS regulation to honor the above grace periods for the Case Management Review to be completed. This will allow sufficient time to recieve provider documentation, assess the information received in order to complete a quality CM review. Furthermore, if the expectation becomes that the provider and CM reviews are due on the same day (15 calendar days from the date review is due), it is likely that provider reviews will not be received until the 15th day which would not allow the CM the opportunity to review the documentation in a timely manner in order to complete their review thoroughly and remain in compliance.	
David Meadows	I wanted offer comment to the proposed regulation indicating that the quarterly reviews need to be in the individual's record no later than 15 calendar days from the date the review was due to be completed. This is a concern for Case Managers/Support Coordinators as they	

Commenter Name	Comments	Response
	need to receive and review the providers quarterly reviews incorporating the information in their review. There are occasions in which the provider is late or does not provide quarterly documentation at all, even with numerous follow up by the CM/SC. This regulation will prevent the CM/SC an opportunity to review the provider quarterlies and synthesize the information as needed. It would also create a potential citation for not meeting a regulation when it is not within their control. Can the regulation be edited to offer a period of time for the CM/SC to review provider quarterlies and then complete the Case Management quarterly? Thanks so much for reviewing the information and working to resolve. If you have any questions or follow up please do not hesitate to contact me directly.	
John Malone	There is some confusion as to whether support coordinators are included in the defintion of "provider" noted here. If they are, this would institue an unwelcome change which reduces the amount of time support coordinators have to complete and document a quarterly review. If support coordinators are not intended to be included in the definition of "provider" in this instance, this should be clarified.	
Michele M. Elliott	There is concern about the change in due dates for reviews. Currently direct service providers are required to send their quarterly report to the Case Manager within a 10 day grace period and the Case Manager then has 30 days from the end of the quarter to review the services provided. There are several providers who do not send their quarterly reports within the 10 days and some that do not send the report by the Case Manager's 30 day grace period. For example, in the month of December 2018, Hanover County DD Services had a total of 57 quarterlies to complete by December 31, 2018; 21 were not received within the 10 day grace period. The Hanover County Case Manager's standard response is to	

Commenter Name	Comments	Response
	follow up with the provider with at least two phone calls and then a standard letter is sent to the provider which is copied to the DBHDS Community Resource Consultant. By December 31, 2018, 15 quarterlies were not received by the case manager's 30 day grace period. In January, 45 quarterlies were due, 18 were not received by the 10 day grace period and 7 were not received by the end of the month after the Case Manager's attempts to receive the review. If the Case Manager is going to be required to complete a quarterly review by the 15th day of the month, then provider information will likely not be included. To meet the expectations of the DOJ Settlement, Case Managers must have the time to review the provider information. We would like to suggest that the providers of direct services be allowed a 15 day grace period to complete their quarterly and that Case Management services be required to complete the quarterly review no later than 30 calendar days from the date of the end of the review period. We would also like to see language added to describe how providers are to be held responsible by Licensure if a quarterly is not received within the grace period, as well as a description of expectations of the Case Manager in obtaining the quarterly. Language should also be added to reflect the responsibility of DBHDS staff in providing oversight to those providers who consistently miss sending requested quarterly information. Thank you for your consideration of these comments. If you need any further information, please feel free to contact me.	
Mary Harrison	The proposed licensing change does not align with the regulations set by DMAS regarding ID/DD case management documentation. Per DMAS guidelines, the Support Coordinator (SC) is permitted a 30-day grace period to complete the person-centered review (quarterly). In addition, providers are allowed a 10-day window (within the 30 day period) to complete and submit their provider QRs to the SC. The SC is	

Commenter Name	Comments	Response
	responsible for obtaining, reviewing and incorporating all provider quarterlies into the person-centered review. The proposed licensing regulation would not allow the SC time to obtain the needed documentation from external providers and complete the person-centered review within the required timeframe. The recommendation would be for the licensing regulation to align with the DMAS regulations to allow a 30-day window to complete the person-centered review.	
Jonina Moskowitz	We sincerely appreciate the efforts of the Office of Licensing to improve coordination with the requirements of the Department of Medical Assistance Services on the topic of quarterly progress reviews. As stated, the proposed change is unclear regarding whether or not the progress review itself may be completed within 15 days of the end of the quarter, or only the documentation of said review. We request language clarification such that the actual review may be completed within a specified window after the end of the quarter. This is a more natural process, as the documentation of such a review is typically completed concurrent with the actual review of affiliated information (e.g. progress notes, summaries provided by other providers). In addition, we request an alteration of the approach, using previously articulated DMAS requirements for providers of intellectual disability services, wherein a reasonable grace period (e.g. 15 days) is allotted to providers of services other than case management, while a more extended grace period is allotted to case managers (e.g. 30 days). This will allow case managers the opportunity to review and synthesize information from other providers into their review and their updates to the ISP, a key requirement of this service and an expectation for support coordinators assisting individuals with developmental disabilities.	

Commenter Name	Comments	Response
(no name given)	The proposed requirement of having the quarterly reviews in the individual 's record no later than 15 calendar days from the day the review was due to be completed is very alarming when it comes to the IDD Case Management /Support Coordination. This will create an issue for the IDD Case Managers /Support Coordinators require to incorporate into the review information from provider(s) who are not always provide the documentation in timely manner. In order to remain with Licensure compliance and DOJ settlement agreement, the staff must provider summary of the individual progress, lack of progress assessment of the person's identified and unidentified risk. We strongly advocate for that the regulation to exclude the IDD Case Management /Support Coordination from the requirement of having Quarterly Review documentation in record no later than 15 days from the date the review period ended. IDD Case Management ought to complete the the Review documentation and add to the individual's record no later than 30 calendar days from the date the review period ended.	
Vicki Ewing	*via email* It would be helpful for all of the regulations to conform, however, since CM/SC must review progress made by the providers of direct service, there should be a difference in the requirements for completion of the quarterly review. See specific comments. Comments There is concern about the change in due dates for reviews. Currently direct service providers are required to send their quarterly report to the Case Manager within a 10 day grace period and the Case Manager then has 30 days from the end of the quarter to review the services provided. To meet the expectations of the DOJ Settlement, Case Managers must have the time to	

Commenter Name	Comments	Response
	review the provider information. Extending the time for Case Managers will allow sufficient time to receive provider documentation, assess the information received in order to complete a quality CM review. Furthermore, if the expectation becomes that the provider and CM reviews are due on the same day (15 calendar days from the date review is due), it is likely that provider reviews will not be received until the 15th day which would not allow the CM the opportunity to review the documentation in a timely manner in order to complete their review thoroughly and remain in compliance. By having different dates, it allows for the complete process required by both Licensure and DMAS to be completed and result in a quality assessment of the implementation of the ISP. Therefore, we would like to suggest that the providers of direct services be allowed a 15 day grace period to complete their quarterly and that Case Management services be required to complete the quarterly review no later than 30 calendar days from the date of the end of the review period.	
Melanie Bond	The proposed changes to the DBHDS regulation are welcomed, given the Department's attempt to align the requirements put forth by DMAS and DBHDS governing licensed behavioral healthcare Providers. However, the proposed changes should ensure its additions will not contradict the current operations of Case Management/Support Coordination in the completion of related tasks. More specifically, this updated section of regulation [12VAC35-105-675], similar to the original, does not identify whether CM/SC staff is included in the definition of Provider. Clarification of this might require extension of the proposed quarterly submission and filing timelines to accommodate CM/SC responsibilities of acquiring collateral documents from other providers, appraisal and incorporating into quarterly review	

Commenter Name	Comments	Response
	documentation. A blanket 15-days for completion and submission into the medical record for all Providers is not sufficient in this respect.	

Public Participation

Please include a statement that in addition to any other comments on the regulatory change, the agency is seeking comments on the costs and benefits of the regulatory change and the impacts of the regulated community. Also, indicate whether a public hearing will be held to receive comments.

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

Anyone wishing to submit written comments 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. Written comments must include the name and address of the commenter. Comments may also be submitted by mail, email, or fax to Emily Bowles, Legal and Regulatory Manager, DBHDS Office of Licensing, PO BOX 1151, Richmond, Virginia, 23218-1151, phone (804) 225-3281, fax (804) 692-0066, emily.bowles@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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

Detail of Changes

Please 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.

If the regulatory change will be a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory change. Delete inapplicable tables.

If the regulatory change is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below. Please include citations to the specific section(s) of the regulation that are changing.

For changes to existing regulation(s), please use the following chart:

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
675 B		B. The provider shall update	Proposed Changes:

		the ISP at least annually. The provider shall review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. These reviews shall evaluate the individual's progress toward meeting the plan's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.	B. The provider shall: (i) update the ISP at least annually; ~~. The provider shall~~ (ii) complete quarterly ~~review~~ reviews of the ISP. The provider shall review the ISP at least every three months from the date of the implementation of the comprehensive ISP ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~. These reviews shall evaluate the individual's progress toward meeting the ~~plan's~~ ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due. Intent, rationale, and likely impact: Per DMAS guidelines, the case manager/support coordinator (SC) is permitted a 30-day grace period to complete the person-centered review (quarterly). This is critically important for SCs to meet the expectations for oversight of services as indicated in the Settlement Agreement. Other providers of direct services will be allowed a 15-day grace period to complete quarterly reviews. The changes are intended to resolve misalignment between DBHDS and DMAS regulations concerning quarterly reviews of ISPs, or a revised assessment, by allowing practitioners to follow the same process rather than two different processes, yet allowing for the requirements related to the Settlement Agreement. This phrase is redundant: ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~.