Office of Comprehensive Services
Empowering communities to serve youth

Use of State Pool Funds for Community-Based Behavioral Health Services Frequently Asked Questions

1. What services are affected by this policy?

The policy adopted by the State Executive Council on July 31, 2013 applies to three community-based behavioral services that are regulated by the Department of Medical Assistance Services (DMAS) and commonly purchased with state pool funds. The services are: Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services. Services in which parents are the identified recipient are not affected by the policy.

2. Does this policy limit the decision-making authority of the local FAPT, i.e., erode local control over the CSA program?

Implementation of the CSA is a shared responsibility between the state and local governments. Both have specific statutory responsibilities for assuring services to at-risk youth and families. The Act provides flexibility to local governments by granting them authority to develop policies and procedures that will enable the community to meet the unique needs of its children, youth and families. Those policies and procedures, however, must comply with the requirements of the Act and policies established by the State Executive Council which holds statutory responsibility for governance of the program.

3. Why are DMAS regulations being applied to CSA?

The stated mission of the Comprehensive Services Act is to "create a collaborative system of services and funding…" The CSA was enacted to bring agencies together to deliver services to children, youth and families for the purpose of eliminating silos and reducing disparities in access to funding and services across the Commonwealth. This policy supports the mission of the CSA by ensuring consistency in how children access Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services and ensuring consistency in the services that are delivered to them – regardless of the funding that is used to purchase those services.

4. Are there other agency regulations that apply to CSA in the same way?

Yes. The application of DMAS regulations regarding these community-based behavioral health services parallels the application of laws and regulations that govern foster care services (e.g., Title IV-E of the Social Security Act); laws and regulations that govern services to students with disabilities (e.g., Individuals with Disabilities Education Act, "IDEA," and "Regulations Governing Special Education Programs for Children with Disabilities in Virginia"); and regulations governing licensure of facilities and services (e.g., licensing regulations of the Department of Behavioral Health Services, Department of Social Services, and Department of Education). Appropriate use of state pool funds requires that communities comply with "any other state law or policy, or any federal law pertaining to the provision of any service…"

5. What impact will this policy have on services to children, youth and families?

This policy supports Virginia's commitment to a comprehensive system of care, i.e., a collaborative system of services and funding. Through assurance that appropriate assessments are utilized to match services to the specific needs of children/youth and through assurance that services are clearly and consistently defined, the policy will improve the quality of services purchased through CSA pool funds and contribute to attainment of better outcomes for Virginia's children, youth and families. Better services and better outcomes will result in more effective use of financial resources and maximum availability of resources for those in need.

6. Does this policy require a VICAP assessment in order to access Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services?

No. Because the services that are addressed by this policy are services designed to meet mental/behavioral health needs, the policy requires that a licensed mental health professional indicate that the services are in fact appropriate to meet the identified mental/behavioral health needs of the child or youth. Having a VICAP assessment completed is one means by which the locality may document the assessment and approval of a licensed mental health professional. The locality may also, however, document the assessment and approval of a licensed mental health professional through his/her signature on the individual family services plan (IFSP). The licensed mental health professional may be a member of the FAPT or may review the FAPT assessment and the service plan subsequent to the FAPT meeting. The licensed mental health professional could be a member of the CPMT which approves funding for services recommended by the FAPT in the individual family services plan.

7. Will a determination of medical necessity or a VICAP be required for all CSA services in the future?

No. The determination of medical necessity was designed for the very specific purpose of assuring that community-based behavioral services are appropriate to meet the needs of a child or youth. CSA funding is utilized to purchase a broad array of services, many of which are not behavioral health services. It would not be appropriate to require a medical assessment, e.g., VICAP, for the broad array of services funded under the CSA.

8. Does the policy require a licensed mental health professional (LMHP) to be on the FAPT?

No. Having an LMHP on the FAPT is only one means by which the FAPT may satisfy the requirement of this policy to have an LMHP certify the appropriateness of the services to meet a child/youth's needs. The LMHP may review the FAPT assessment and individual family services plan subsequent to the meeting. Additionally, the FAPT may refer children/youth to the community services board for completion of a VICAP assessment.

9. Will the requirement to have a licensed mental health professional approve the need for services increase costs to the locality?

Not necessarily. The locality has flexibility in how it meets this requirement. While a locality may not have a licensed mental health professional readily available to serve on its FAPT, its CPMT, or to review the FAPT assessment and individual family services plan subsequent to its meeting, all communities have access to the VICAP assessment process through a community services board. The locality does share in the cost of the VICAP assessment, and thus there is increased cost for such assessment. In the longer-term, however, research shows that the use of appropriate assessment to properly match services to the specific needs of children and youth reduces use of unnecessary services and multiple services, and produces better outcomes for children, youth and families. The initial investment in appropriate assessment is fully anticipated to increase the effective and efficient utilization of financial resources, i.e., to reduce the overall cost of services.

10. If a locality does not have a licensed mental health professional (LMHP) available to serve on the FAPT, how can it meet the requirement that an LMHP must certify the appropriateness of services?

Each community has the flexibility to determine the most effective means by which to meet the policy requirement that a LMHP assess and approve the services addressed by this policy. The LMHP may review the FAPT assessment and individual family services plan subsequent to the FAPT meeting or the child/youth may be referred to the local community services board for a VICAP assessment.

11. If the licensed mental health professional (LMHP) who serves on FAPT and/or reviews the IFSP works for the local community services board (CSB), does that mean the CSB cannot provide services to the child/youth identified for services?

No. The provision requiring that the LMHP not be the direct service provider or supervise the direct service provider assures protection against conflict of interest. As long as the LMHP is not the same person who will be serving the child/youth or will not be the direct supervisor of the person serving the child/youth, there would not be a conflict of interest. The LMHP may be employed by the same agency of the individual to serve the child/youth as long as he/she will not be directly providing or supervising the services to the child/youth. Exceptions to this requirement are allowable where there are limited resources and in which the LMHP recuses him/herself from involvement in making the referral to a specific service provider. This provides appropriate protection against conflict of interest.

12. Does the licensed mental health professional (LMHP) have to conduct a formal assessment equivalent to the assessment completed for the VICAP?

The policy recognizes that a primary function of the FAPT is to assess the strengths and needs of each child/youth. The FAPT assesses the strengths and needs through review of the CANS, information provided by the child/youth and family, information provided by the agencies and entities working with the child/youth and family, and other sources of information available to the team. Documentation of the FAPT assessment, with evidence of the LMHP review and support of the services recommended, is sufficient to meet the

documentation requirements of assessment required by the policy. Specifically, the requirement is that the LMHP indicate his/her opinion that the child meets the medical necessity criteria for the specified service detailed in the DMAS regulations (See the appropriate DMAS regulation for the specific community-based behavioral health service).

13. **Must a child/youth have a mental health diagnosis (e.g., DSM diagnosis) in order to receive Intensive In-Home, Therapeutic Day Treatment, or Mental Health Support Services?**

Yes. Because the services addressed in this policy are mental/behavioral health services, access to the services does require meeting the criteria of medical necessity which are established in DMAS regulations. A preliminary diagnoses or deferred diagnoses may be provided as evidence of medical necessity in the FAPT documentation; however, a diagnosis must ultimately be established through the service-specific provider assessment that must be completed within 30 days of the initiation of the service. State Pool funds may not be used to pay for services beyond the 30-day time frame unless the service-specific provider assessment is complete and contains a diagnosis.

It is not appropriate nor expected that the LMHP make a diagnosis based on information presented to the FAPT. However, if a diagnosis is already available from the child's records or reported to the FAPT from a documented source, it may be noted as such on the FAPT documentation.

14. What documentation should the FAPT maintain to demonstrate that a child/youth meets the service criteria for each of the services?

It is recommended that the locality document the basis for its determination of medical necessity in FAPT minutes or in the IFSP and include supporting information in the case record. A sample form for documenting medical necessity will be made available, but is not required.

15. What happens to a child/youth and family when the child/youth does not meet the criteria for one of these services, but the FAPT believes services are needed?

This policy does not prevent the provision of appropriate services to children, youth and families. When a child/youth's needs do not meet the medical necessity criteria established by DMAS regulations, the FAPT/CPMT is not restricted in the provision of alternative services, i.e., services other than Intensive In-Home, Therapeutic Day Treatment, or Mental Health Support Services. In addition, the policy allows the CPMT to apply for an exception to the policy when it believes there are exceptional circumstances that apply to an individual child/youth which warrant an exception to the policy.

16. Will this policy prevent children/youth who have suffered trauma but don't have a mental health diagnosis from receiving services?

While it is likely that most children/youth who exhibit symptoms resulting from trauma will qualify for a mental health diagnosis, e.g., adjustment disorder, a diagnosis is not be required in the FAPT documentation.

However, as discussed in Question 13, the establishment of a diagnosis will be required within 30 days of the initiation of services as part of the service-specific provider assessment. If that assessment is unable to establish a mental health diagnosis, CSA will not authorize any continued funding.

17. What happens when a child/youth is in crisis and services are needed immediately to protect his/her safety and/or the safety of others?

This policy does not prohibit the provision of emergency services that are necessary to address crisis circumstances. The services addressed by this policy are not emergency services. The policy defines the terms "crisis" and "emergency services" to ensure clarity that there is nothing in the policy that interferes with a locality's ability to address crisis circumstances and/or to utilize emergency services.

18. What happens when a Medicaid-eligible child/youth meets the criteria for services but there is not a Medicaid-eligible provider in our area to provide the service?

DMAS has contracted with Magellan to serve as the administrator of behavioral health services for Medicaid-eligible clients. Magellan is charged with responsibility to build a network of service providers to ensure maximum access to services across the Commonwealth. Magellan will provide resources to assist localities in the identification of service providers (e.g., web-based search capability and phone consultation). If a service provider cannot be located, the policy allows for the CPMT to request an exception to the policy through the Office of Comprehensive Services. Approval of an exception will enable the locality to utilize state pool funds to purchase services from a non-Medicaid eligible provider when necessary.

19. Does the FAPT/CPMT have responsibility to hold service providers accountable for implementing the DMAS regulations regarding these services?

Yes. In addition to identifying the medical necessity criteria for services, DMAS regulations identify provider qualifications and specific service requirements. CSA statutes require that each CPMT have policies and procedures to conduct utilization review (UR) of the services purchased through CSA state pool funds. Understanding service components and assuring that they are appropriately delivered is a function of utilization review as well as an expectation for general contract monitoring and accountability for purchased services. Through its UR activities, the locality is responsible to assure that providers are delivering the contracted services to youth. Because the services covered by the policy are licensed through the Department of Behavioral Health and Developmental Services (DBHDS), providers are also subject to oversight by DBHDS for compliance with licensing requirements.

20. How does a locality know which DMAS regulations are relevant to this policy?

Implementation guidelines to accompany the policy were approved by the State Executive Council. These guidelines identify the specific sections of DMAS regulations that pertain to Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services. Training will be provided to local communities on the policy, the guidelines, and the relevant regulations and resources will be posted to the CSA website Resource Library.

21. When does this policy go into effect?

Compliance with the policy will be required for all new individual family services plans developed on or after October 1, 2013. Compliance with the policy will be required for all individual family services plans by July 1, 2014. Localities will be subject to denial of funds for failure to comply with the policy beginning July 1, 2014.

22. If a provider is asked to deliver individualized services other than intensive in-home counseling, Mental Health Support or therapeutic day treatment with the child as the identified client, what licensure requirements will exist?

Providers should clearly define the service being provided and ensure that this is the service that is delivered. With a clear definition of the service, the provider, in consultation with the DBHDS Office of Licensure can determine if that particular service needs to be licensed. Some services may need to be licensed (e.g., Intensive In-Home, Supportive In-Home Services) and others may not (e.g., mentoring, parent support). Services to address the needs of parents or family members (e.g., counseling) may be required to be licensed.

23. If a service is provided by an individual who is licensed through the Board of Health Professions (e.g., LCSW, LPC), does the service in which that individual is working need to be licensed by DBHDS?

No. Services are licensed by DBHDS depending on the nature and elements of the service, not the qualifications of the person providing the service.