Community Mental Health and Rehabilitative Services Regulatory Changes

CSA Conference
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DMAS Regulation Changes

- Regulation changes went into effect as of January 30, 2015 for DMAS Community Mental Health and Rehabilitative Services.
- This presentation will review the changes.
- DISCLAIMER:
- THIS PRESENTATION IS NOT MEANT TO SUBSTITUTE FOR THE COMPREHENSIVE PROVIDER MANUAL OR STATE AND FEDERAL REGULATIONS.
- The Community Mental-Health Rehabilitation Services manual is located at:
- https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual
- Final regulations are located on the Virginia Regulatory Town Hall at: http://townhall.virginia.gov/L/ViewXML.cfm?textid=9322

"BHSA" as Defined in the MHSS Emergency Regulations

- Magellan Health serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the behavioral health benefits program under contract with DMAS. Magellan is authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and the designated BHSA. DMAS shall retain authority for and oversight of the BHSA entity or entities.
- Providers under contract with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Memo Issued March 16, 2015

- The changes being implemented are due to the approval of final regulatory changes that were developed and shared with stakeholder groups from 2011 through 2013.
- DMAS collected public comments on the regulations from August to September, 2011 and again from February through April, 2013.
- The final regulatory changes were based on the changes defined in the Emergency Regulation package that was in effect from July 18, 2011 through January 16, 2013.
- The previous Emergency Regulations package defined most of the changes that these final regulations incorporate into the administrative code.
- The text of the regulations and these changes has been publicly available on the Virginia Regulatory Town Hall since June, 2014.

Regulation Sections in Administrative Code

Some cross references are present that refer to the children's regulation sections for definitions used in adult services. Ex: "Service Specific Provider Intake" is defined in the children's section but referenced in the adult services as a requirement. Individual Service Plan is defined in the Adult section but referenced in children's service sections.

Covered Services Children
- http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section130

Covered Service Adult
- http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section226/

UR criteria and MNC criteria in general:
- http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section5/

UR and MNC children's
- http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section61/

UR and MNC Adult
- http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section143/

Marketing:
- http://law.lis.virginia.gov/admincode/title12/agency30/chapter130/section2000

Changes in Service Authorization Processing at Magellan: June 1, 2015

- As of January 30, 2015 the new regulations are in effect.
- Case Management Registrations may be processed right now
- Staff requirements, licensing requirements, service plan requirements, service specific provider intake and procedural changes must be in compliance with the regulations.
- Magellan will implement the new program requirements and verify that new requirements are met by providers on all *new* service requests and *continued stay/concurrent review* requests beginning on June 1, 2015.

- Providers are expected to adhere to all new regulatory changes as of January 30, 2015.

CMHR Services NOT Impacted

- Mental Health Skill-building Services
- MH Case Management* (*no changes to service model or requirements*)
- Substance Abuse Crisis Intervention
- Substance Abuse Intensive Outpatient Treatment
- Substance Abuse Day Treatment
- Opioid Treatment
- Residential Substance Abuse Treatment for Pregnant and Post Partum Women
- Substance Abuse Day Treatment for Pregnant and Post Partum Women
- Substance Abuse Case Management

Mental Health Services

- Services, *in order to be covered*, shall meet medical necessity criteria based upon diagnoses made by LMHPs who are
  - Practicing within the scope of their licenses and are
  - Reflected in provider records and on providers' claims for services by
  - Recognized diagnosis codes that support and are consistent with the requested professional services.
- Services are intended to be
  - Delivered in a person-centered manner.
  - The individual shall be included in all service planning activities.
  - All services which do not require service authorization require registration (This does not apply to substance abuse services).
  - This registration shall transmit to DMAS or its contractor (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code and begin date of the service; and (iii) the provider‘s name and NPI, a provider contact name and phone number, and email address.

LMHP Definition

- As Defined in 12VAC35-105-20 (DBHDS Regulations)
- "Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

New Definition for LMHP "Types"

As defined in 12VAC30-50-130:

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

New Definition for LMHP "Types"

As defined in 12VAC30-50-130:

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

New Definition for LMHP "Types"

As defined in 12VAC30-50-130:

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" is defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

Service Specific Provider Intakes*

Service-specific provider intake (SSPI) means the evaluation that is conducted according to the Department of Medical Assistance Services as defined in 12VAC30-50-130. The SSPI defines the clinical necessity of the service and defines the treatment needs to be addressed by the service plan

- Unless otherwise specified, service-specific provider intakes shall be conducted by:
- A licensed mental health professional (LMHP);defined in 12VAC35-105-20
- LMHP-supervisee, LMHP-supervisee in social work or LMHP-S;
  - Supervisee is defined in 18VAC140-20-10
- LMHP-resident or LMHP-R; or
  - Resident is defined in 18VAC140-20-10
- LMHP-resident in psychology or LMHP-RP*
  - Individual in residency is defined in 18VAC140-20-10
    - (**This change does not apply to Case Management)*

SSPI Requirements

- Service-specific provider intake includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements:

(i) the presenting issue/reason for referral,
(ii) mental health history/hospitalizations,
(iii) previous interventions by providers and timeframes and response to treatment,
(iv) medical profile,
(v) developmental history including history of abuse, if appropriate,
(vi) educational/vocational status,
(vii) current living situation and family history and relationships,
(viii) legal status,
(ix) drug and alcohol profile,
(x) resources and strengths,
(xi) mental status exam and profile, *NEW*
(xii) diagnosis,
(xiii) professional summary and clinical formulation,
(xiv) recommended care and treatment goals, and
(xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

Provider and Case Management Coordination

Should the individual receiving CMHRS *(except ICT*)* be enrolled in Case Management Services, it is required that the service provider have a minimum of the following contact with the Community Services Board or Behavioral Health Authority case manager:

1. Notify the CSB/BHA case manager that the individual is enrolled with the service provided.

2. Send monthly updates of the individual's status to the CSB Case Manager.

3. Send a discharge summary to the case manager within 30 days of the service discontinuation date.

ISP Changes

- Service plans define what providers will be reimbursed for through the services based on the assessed needs of the individual being served.

- Goal and Objective requirements will be more thoroughly defined to better guide and increase quality based and measurable service planning

- Care or Service Coordination related objectives will be defined to better assist the coordination of care between provider agencies and case managers to help align all service plans and to prevent any counterproductive activities or interventions.

  Ex: a MHSS provider would have to include an objective to coordinate service delivery with the individuals other providers and medical providers as needed to implement a specified goal or objective in their service plan for MHSS.

- Discharge planning and ongoing plan revisions based on the needs of the individual are now specifically required by regulatory language.

Individual Service Plan

As defined in 12VAC30-50-226, the ISP is a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs ***as identified in the clinical assessment.***

The ISP contains:

- Treatment or training needs,
- Goals and measurable objectives to meet the identified needs,
- Services to be provided with the recommended frequency to accomplish the ***measurable*** goals and objectives,
- Estimated timetable for achieving the goals and objectives, and
- Individualized discharge plan that describes transition to other appropriate services.
- The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

Case Management vs. Service Coordination

- Case Management is a stand alone service that supports the global needs of the individual in any or all realms of life related to level of functioning.
  - Example: assisting a client/family in obtaining resources based on input from the member or other service providers involved in the care.
- Service Coordination is activity that enhances the benefit of the specific service for the member/family.
  - Example: exchanging information with a psychiatrist about observations of a child's behavior during sessions to optimize interventions defined in the Individual Service Plan.

Children's Services: Therapeutic Day Treatment

Changes:

- New definitions for At Risk and Out of Home Placement
- New VICAP Processing requirements for those deemed at risk
- Must adhere to new ISP definition (All Services)
- ISP contains discharge planning and measureable goals and objectives
- ISP is completed in a person centered manner
- Service Coordination is required to coordinate the service with other service providers and persons involved in the individuals care
- Coordination with Case Management is required on a monthly basis
- "Failed services" will not be authorized for payment
  - "Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.

Children's Services: Intensive In-Home Services

Revised Service Definition:

- Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

Children's Services: Intensive In-Home Services

Intensive In-Home Services no longer includes Case Management Services.

Changes:

- New definitions for At Risk and Out of Home Placement
- New VICAP Processing requirements for those deemed at risk
- Must adhere to new ISP definition (All Services) *Strictly defined in IIH*
- ISP contains discharge planning and measureable goals and objectives
- ISP is completed in a person centered manner
- Service Coordination is required to coordinate the service with other service providers and persons involved in the individuals care
- Coordination with Case Management is required on a monthly basis
- "Failed services" will not be authorized for payment
  - "Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.

Children's Services: Intensive In-Home Services

- Case management is removed from IIH due to a federal requirement in 42 CFR § 441.18. The service definition is revised to provide for care coordination which can be referred to as "service coordination" and will include activities designed to implement treatment goals by the service provider.
- Important points to remember!
- Individuals enrolled in IIH and who are in need of Case Management Services may receive these services from their local Community Services Board or Behavioral Health Authority.
- It is not required for the individual enrolled in IIH to receive Case Management.
- Should an IIH provider recognize the need for Case Management Services the individual should be referred to the local CSB to be assessed for this service. If providers need assistance with the referral, Magellan is available to assist them.

Children's Services: At Risk Definition

"At risk" means one or more of the following:

- within the two weeks before the intake , the individual shall be screened by an LMHP for escalating behaviors that have put either the individual or others at immediate risk of physical injury *;
- the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;
- a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of, consultant to the intensive in-home (IIH)] services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident;
- the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health support) within the past 30 days;
- the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either:
  - (a) transitioning out of residential treatment facility Level C services,
  - (b) transitioning out of a group home Level A or B services,
  - (c) transitioning out of acute psychiatric hospitalization, or
  - (d) transitioning between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

Children's Services: Out of Home Placement Definition

"Out-of-home placement" means placement in one or more of the following:

- either a Level A or Level B group home;
- regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services;
- treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care;
- Level C residential facility;
- emergency shelter for the individual only due either to his mental health or behavior or both;
- psychiatric hospitalization; or
- juvenile justice system or incarceration.

Required Activities when individual is screened and determined to be "AT Risk of Physical Injury":

For all individuals that have been screened by an LMHP and meet criteria "i" of the "At Risk Criteria" they are deemed "at risk for physical injury" and the service-specific intake and service authorization process must be managed by the provider according to the following requirements:

- If the individual is deemed at risk of physical injury or the risk assessment determines there is a need for immediate intervention, the provider will work with the appropriate entities (parents, local CSB, local hospital) to come up with a safety plan and conduct an emergency services assessment to assess for the most appropriate level of care.
- Once the individual is referred for community based services the SSPI must be completed by the provider selected by the individual's caregivers. If the SSPI is not completed within 14 calendar days of the LMHP who deemed the individual to be a physical danger to self or others, an additional risk assessment must be completed.
- This risk assessment must be done by an LMHP. It may be the same LMHP who performs the service-specific intake for IIH or TDT.
- If a VICAP was done, the original VICAP assessor may update that assessment if they are available to do so.
- The risk assessment will be submitted along with the Service Request Application to Magellan for review.
- If the SRA is submitted to Magellan for the child who is at risk of physical danger to self or others and is beyond 14 days of the VICAP, the case will be pended and the submitting provider will be contacted and asked to submit this risk assessment to Magellan within three business days.
- Once the risk assessment is received, the information will then be reviewed and a decision made.
- If the provider does not submit the additional requested information, the service may not be authorized

Community-based services for children and adolescents under 21 (Level A and B).

- Service Specific Provider Intake Required for all cases
- Care coordination is now a part of Group Home Level A services.
- Should the individual receiving Group Home Level A or B services be enrolled in Case Management Services, it is required that the Level A or B service provider have a minimum of the following contact with the Community Services Board or Behavioral Health Authority case manager:

1. Notify the CSB/BHA case manager that the individual is enrolled Intensive In-Home Services.
2. Send monthly updates of the individual's status to the CSB Case Manager.
3. Send a discharge summary to the case manager within 30 days of the service discontinuation date.

Crisis Intervention

Changes:

- Effective Immediately-Services must be registered with Magellan within one business day *(currently providers have two business days)* of the provision of the service-specific intake. (An authorization is required for any GAP enrollee receiving this service. Soon when the MHSS regulations are finalized the service will require authorization just like GAP)
- The service-specific provider intake (face to face), as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service.
- Provision of services shall be provided by a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or certified pre-screener.
- Providers shall be licensed as a provider of emergency services.
- TDO/ECO Services may be covered

Crisis Stabilization

Changes:

- Effective Immediately-Services must be registered with Magellan within one business day *(currently providers have two business days)* of the provision of the service-specific intake. (*An authorization is required for any GAP recipient receiving this service. Soon when the MHSS regulations are finalized the service will require authorization just like GAP*)
- A face to face service-specific intake must be completed by an LMHP, LMHP-supervisee, LMHP Resident, LMHP-RP, or Certified Pre-Screener.
- Provision of services shall be provided by a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a certified pre-screener.
- Residential Crisis Stabilization providers shall be licensed as providers of mental health residential crisis stabilization services.
- Providers of community-based crisis stabilization shall be licensed as providers of mental health nonresidential crisis stabilization.

Progress Notes and General Documentation Requirements

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

Provider Impacts

Are the staff qualifications in the regulations currently in effect?

- ANSWER: Yes. The staff qualifications went into effect on January 30, 2015. DMAS worked closely with the Department of Behavioral Health and Developmental Services and the Department of Health Professions to ensure that DMAS requirements align with the provider and practitioner licensing requirements issued by these agencies. These changes were subject to public comment. In addition, DMAS discussed LMHP and QMHP staff qualification issues with providers regularly as these regulations were being developed and promulgated. (As a result, additional types of LMHPs and QMHPs are permitted to provide services.)

Will the new regulations affect documentation requirements?

- ANSWER: Yes. Documentation in the clinical record must be in compliance with and reflect the new regulatory language, consistent with the effective date of these regulations. Additionally, documentation submitted for service authorization will be validated within the clinical record upon post payment review. Inconsistencies may be subject to retraction and/or referral to the Medicaid Fraud Control Unit (MFCU) within the Office of Attorney General.

Provider Questions

In the weeks since the regulations have become effective, providers have raised several questions, which are answered below.

Can private providers be reimbursed for Crisis Intervention Services?

ANSWER: Yes. The new DMAS regulations require providers to be licensed as Emergency Services providers. This requirement will not prevent providers who are already providing crisis intervention services, and who hold an Outpatient Services license, from providing Crisis Intervention services and receiving Medicaid reimbursement. Providers who are not currently providing Crisis Intervention services, but are interested in doing so, will work with DBHDS to first obtain the appropriate license.

Should IIH and ICT providers stop providing case management services?

ANSWER: Yes*. As a result of federal requirements, the new DMAS regulations prohibit IIH and ICT providers from including case management as a component of those services. Instead, providers will offer service coordination, which is less intensive. Many individuals who are receiving IIH or ICT will continue to need case management services, and must be referred to their Community Service Board for this service. *DMAS and Magellan are working with the VACSB to transition over 900 ICT cases and over 6,100 IIH (non CCC) cases to active case management based on individual choice.

Thank You!

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