COMMONWEALTH of VIRGINIA
Office of the Attorney General

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Attorney General

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MEMORANDUM

TO: **BRIAN MCCORMICK**
Director, DMAS Policy Division
Department of Medical Assistance Services

FROM: **JENNIFER L. GOBBLE**
Assistant Attorney General

DATE: **November 24, 2014**

SUBJECT: **Emergency Regulations - GAP Demonstration Waiver for Individuals with Serious Mental Illness**

I have reviewed the attached emergency regulations that would implement, subject to approval by the Centers for Medicare and Medicaid Services ("CMS"), a demonstration waiver for the Governor's Access Plan ("GAP") for the Seriously Mentally Ill. The GAP demonstration waiver would provide a targeted, limited behavioral and primary health benefits package to individuals who meet eligibility parameters, as set out in the emergency regulations, resulting from a diagnosis of serious mental illness.

Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services ("DMAS"), acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act ("APA"), and has not exceeded that authority. The attached emergency regulations will enable the Director to implement the GAP demonstration waiver consistent with the authority set forth in Virginia Code § 32.1-324, and Item 301.E.1 of Chapter 2 of the 2014 *Acts of Assembly*.

The authority for this emergency action is found in Virginia Code § 2.2-4011(A), which provides that regulations that an agency finds are necessitated by an emergency situation may be adopted by an agency upon consultation with the Attorney General, which approval shall be granted only after the agency has submitted a request stating in writing the nature of the emergency, and the necessity for such action shall be at the sole discretion of the Governor. The Department's statement of the nature of the emergency and necessity for such action is set forth in the "Agency Background Document." The Agency Background Document also indicates that

the Department submitted a written request to the Governor stating the nature of such emergency.

Pursuant to § 2.2-4012, the attached emergency regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations. In addition, the emergency regulations shall be effective for no more than 18 months. If the Department intends to continue regulating the subject matter governed by these emergency regulations beyond 18 months, it will be necessary to replace these emergency regulations with regulations duly promulgated under Article 2 of the APA. A Notice of Intended Regulatory Action relating to the proposed replacement regulations must be filed with the Registrar within 60 days of the effective date of the emergency regulations. The proposed regulations must be filed with the Registrar within 180 days after the effective date of the emergency regulations. Va. Code § 2.2-4011(C).

If you have any questions or need any additional information, please feel free to contact me at 786-4905.

cc: Kim F. Piner
Senior Assistant Attorney General

Emergency Text

Action:
CH 135 GAP Demo Waiver for Individuals with Serious Mental ...
Stage: Emergency/NOIRA
11/24/14 4:50 PM [latest]

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHALL NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-135-400. GAP Demo Waiver for Individuals with Serious Mental Illness.

This program shall be known as the GAP demonstration waiver for individuals with serious mental illness.

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12VAC30-135-401. Establishment of program.

A. The Commonwealth, through the single state Medicaid agency, The Department of Medical Assistance Services (DMAS) proposes a §1115 demonstration waiver, the *Virginia Governor s Access Plan (GAP) for the Seriously Mentally Ill (SMI).* With federal approval, Virginia will offer a limited yet targeted benefit package of services that builds on a successful model of using existing partnerships to provide and integrate basic medical and behavioral health care services for individuals who have a Serious Mental Illness (SMI) and have incomes less than 100% of the Federal Poverty Limit (below 95% with a 5% income disregard to equal 100% of the FPL).

B. Enabling persons with SMI to access both behavioral health and primary health services will enhance the treatment they can receive, allow their care to be coordinated among providers, and potentially significantly decrease the severity of their condition. The three goals of this program are:

1. Improve access to health care for a segment of the uninsured population in Virginia who has significant behavioral and medical needs;

2. Improve health and behavioral health outcomes of demonstration participants; and,

3. Serve as a bridge to closing the coverage gap for uninsured Virginians.

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12 VAC 30-135-410. Definitions. The following words and terms shall have the following meanings unless the context clearly indicates otherwise:

"Action" means an action by Cover Virginia or the service authorization contractor, that constitutes a termination or denial of eligibility or services or limited authorization of a service authorization request including: (i) type or level of service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) failure to act on a service request; (iv) denial in whole or in part of coverage for a service; or (v) failure by Cover Virginia or the service authorization contractor to render a decision within the required timeframes.

"Agency" means either Cover Virginia or the service authorization contractor.

"Alternative home care" means mental health services more intensive than outpatient provided either in the individual's home or the individual is temporarily (less than two weeks) placed in a therapeutic living setting that provides intensive mental health services such as residential crisis stabilization.

"Appellant" means an applicant for or recipient of GAP benefits who seeks to challenge an action regarding eligibility, services and coverage determinations.

"BHSA" means the behavioral health services administrator entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Behavioral health" means mental health and substance use disorder services.

"CSB" means the local Community Services Board/Behavioral Health Authority agency which is the entry point for citizens into behavioral health and substance abuse treatment services as established in 37.2-500 et seq. and 37.2-600 et seq. of the Code of Virginia.

"Care coordination" means the collaboration and sharing of information among health care providers, who are involved with an individual's health care, to (i) improve the health and wellness of individuals with complex and special care needs and (ii) integrate services around the needs of such individuals at the local level by working collaboratively with all partners, including the individual, his family, and providers.

"CAT' means Computer Aided Tomography.

"Certified prescreener" means an employee of either the local community services board/behavioral health authority, or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DBHDS.

"Client appeal" means an individual's request for review of an eligibility, coverage, or payment determination. An appeal is an individual's challenge to the actions regarding benefits, services, and reimbursement provided by the department, its service authorization contractor, or Cover Virginia.

"Clinical experience" means practical experience in providing direct services on a full-time basis (or the equivalent part-time experience as determined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013, to individuals with medically-documented diagnoses of mental illness or intellectual/developmental disability or the provision of direct geriatric services or full-time (or the equivalent part-time experience) special education services, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health skill-building, (v) crisis stabilization, or (vi) crisis intervention services. Experience shall include supervised internships, supervised practicums, and or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. This required clinical experience shall be calculated as set forth in 12VAC35-105-20.

"Code" or "COV" means Code of Virginia.

Complaint means a grievance as defined herein.

"Cover Virginia" or "Cover VA" means a department contractor which receives applications for the GAP Demonstration Waiver for Individuals with SMI, determines eligibility, and handles individuals' appeal of actions which have denied, reduced, or terminated covered benefits.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"Department" or "DMAS" means the Department of Medical Assistance Services and its contractor or contractors consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Division" means the Appeals Division at DMAS.

"Direct services" means the provision of direct behavioral health and medical treatment, counseling or other supportive services not included in the definition of care management services.

"DSM" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), copyright 2013, American Psychiatric Association.

"Duration of illness" means the individual: (i) is expected to require this program's services for an extended period of time; (ii) has undergone more than once in his lifetime psychiatric treatment more intensive than outpatient care such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization; (iii) has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted his normal living situation.

"Eight dimensions of wellness" means the same as found on the website for the Substance Abuse and Mental Health Services Administration at http://www.promoteacceptance.samhsa.gov/10by10/dimensions.aspx

"Expedited appeal" means the process by which the department must respond to an individual's appeal of an adverse action regarding services if an eligibility or denial of care decision may jeopardize the individual's life, health or ability to attain, maintain or regain maximum function.

"FQHC" means a Federally Qualified Health Center.

"Final decision" means a written determination pertaining to client appeals by a department hearing officer which is binding on the department, unless modified during or after the judicial process and which may be appealed to the local circuit court.

"FPL" means the Federal Poverty Level.

"GAP individual appeal" means an enrollee s request for review of an eligibility or coverage determination. An appeal is an enrollee s challenge to the actions regarding benefits, services, and reimbursement provided by the department, its service authorization contractor, or Cover Virginia.

"GAP case management" means services to assist individuals in solving problems, if any, in accessing needed medical, behavioral health, social, educational, vocational, and other supports essential to meeting basic needs, including: (i) assessment and planning services, including developing an Individual Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment); (ii) linking the individual to services and supports specified in the Individual Service Plan; (iii) assisting the individual for the purpose of locating, developing or obtaining needed services and resources; (iv) coordinating services and service planning with other agencies and providers involved with the individual; (v) enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services; (vi) making collateral contacts with the individuals' significant others to promote implementation of the service plan and community adjustment; (vii) follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and; (viii) education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

"Good cause" means to provide sufficient "cause" or reason for failing to file a timely appeal or for missing a scheduled appeal hearing. The existence of good cause shall be determined by the department.

"Grievance" means an expression of dissatisfaction about any matter other than an "action." A grievance shall be filed and resolved at Cover Virginia or the service authorization contractor. Possible subjects for grievances include, but shall not be limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee s rights.

"Hearing" means an informal evidentiary proceeding conducted by a department hearing officer during which an individual has the opportunity to present his concerns with, or objections to, the action taken by Cover Virginia or the service authorization contractor.

"Hearing officer" means an impartial decision maker who conducts evidentiary hearings on behalf of the Department.

"Human services field" the same as defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual" means the client, enrollee, or recipient of services described in this section.

"Individual service plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the clinical assessment.

"Intensive outpatient services or "IOP" means services for individuals who have substance use disorders that are provided in a nonresidential clinical setting scheduled a maximum of 19 hours of services per week. IOP is targeted to individuals who require more intensive services than outpatient counseling services. Intensive outpatient services are provided in a concentrated manner, and generally involve multiple outpatient visits per week over a period of time for individuals requiring stabilization. IOP services include monitoring and multiple group therapy sessions during the week, and individual and family therapy which are focused on the Medicaid eligible individual. The maximum annual limit is 600 hours.

"Level of disability" means, for the purpose of this program's regulations, (i) evidence of severe and recurrent disability resulting from mental illness, and; (ii) evidence of functional limitation in major life activities resulting from mental illness.

"Licensed Mental Health Professional" or "LMHP" means a 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.

"LMHP-resident" or "LMHP-R" means the same as "resident" is defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18 VAC115-50-10 for licensed marriage and family therapists; or (iii) 18 VAC115-60-10 for licensed substance abuse treatment practitioners.

"LMHP-Resident in Psychology" or "LMHP-RP" means the same as an individual in a residency program as defined in 18VAC125-20-10for clinical psychologists.

"LMHP-Supervisee in Social Work" or "LMHP-S" means the same as "supervisee" is defined in 18 VAC140-20-10 for licensed clinical social workers.

"MRI" means Magnetic Resonance Imaging.

"Peer services" means supportive services provided by adults who self-disclose as living with or having lived with a behavioral health condition and includes: (i) planning for engaging in natural community support resources as part of the recovery process; (ii) help to initiate rapport with therapists; (iii) increase teaching and modeling of positive communication skills with individuals to help them self-advocate for individualized services to promote successful community integration strategies.

"PSN" means a Peer Support Navigator who has self-declared that he is living with or has lived with a behavioral health condition. PSNs assist individuals to successfully remain in or transition back into their communities from inpatient hospital stays, help them avoid future inpatient stays, and increase community tenure by providing an array of linkages to peer run services, natural supports, and other recovery oriented resources.

"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.

"Psycho-educational activities and services" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes individuals' and families' needs and focuses on increasing individuals' and families' knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in 12VAC35-105-20.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as defined in 12VAC35-105-20.

"Qualified substance abuse professional" or "QSAP" means the same as defined in 12 VAC 35-105-20.

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving services that do not require service authorization.

"Remand" means the return of a case by the hearing officer to Cover Virginia or the service authorization contractor for further review, evaluation, and action.

"Representative" means an attorney or other individual who has been authorized to represent an applicant or enrollee pursuant to these regulations.

"Resident" means the same as defined in 18 VAC 115-20-10 and shall apply to Licensed Mental Health Professionals (LMHPs).

"Reverse" means to overturn the action of Cover Virginia or the service authorization contractor and direct that eligibility or requested services be fully approved for the amount, duration, and scope of requested services.

"SMI" or "Serious Mental Illness" means, for the purpose of these regulations, a diagnosis of: (i) schizophrenia spectrum disorders and other psychotic disorders but not substance/medication induced psychotic disorder; (ii) major depressive disorder; (iii) bipolar and related disorders but not cyclothymic disorder; (iv) Post-Traumatic Stress disorder; (v) other disorders including obsessive-compulsive disorder, agoraphobia, anorexia nervosa, or bulimia nervosa.

"SMI screening entity" means the entity that conducts the SMI screening for the GAP SMI program; shall be a CSB or participating FQHC or an inpatient psychiatric hospital or general hospital with an inpatient psychiatric unit, and; shall be conducted by a qualified provider for the purpose of determining eligibility for participation in the GAP SMI program.

"Service authorization" means process to approve specific services for an enrolled GAP individual prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS' and DMAS' contractor criteria for reimbursement.

"Secretary" means the Secretary of the U.S. Department of Health and Human Resources of the U.S. Department of Health and Human Resources.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the individual and his parent or other family member or members, as appropriate, about mental health status. It 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 the 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, (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.

"State fair hearing" means DMAS evidentiary hearing process as administered by the DMAS Appeals Division.

"State Plan" or "the Plan" means the document required by § 1902(a) of the Act.

"Supervisee" means the same as defined in 18 VAC 115-20-10 and shall apply to Licensed Mental Health Professionals (LMHP-S).

"Sustain" means to uphold the action of Cover Virginia or the service authorization contractor.

"Title XIX of the Social Security Act" or "the Act" means the United States Code beginning at 42 U.S.C. § 1396.

"Virtual engagement" means telephonic communications between a peer specialist and GAP enrolled individual to discuss and promote engagement with resources that may be available to the individual to promote his recovery.

"Warm line" means a peer-support telephone line that provides peer support for adults individuals who are living with or have lived with behavioral health conditions. The peers shall have specific training to provide telephonic support and such systems may operate regionally or statewide and beyond traditional business hours.

"Withdrawal" means a written request from the applicant or enrollee or his representative for the department to terminate the appeal process without a final decision on the merits.

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12VAC30-135-420. Administration; authority; waived provisions. .

A. DMAS shall cover a targeted set of services as set forth in 12 VAC 30-135-450 for currently uninsured individuals who have diagnoses of Serious Mental Illnesses with incomes below 100 percent of the Federal Poverty Line (FPL) (below 95% of the FPL plus a 5% household income disregard).

B. Consistent with § 1115 of the Social Security Act (42 U.S.C. 1315), the department covers certain limited services specified in 12 VAC 30-135-450 for certain targeted individuals specified in 12 VAC 30-135-430.

C. The Secretary has waived compliance for the department with the following for the purpose of this demonstration waiver program:

1. Consistent with § 1902(a)(10)(B) of the Act, the amount, duration, and scope of services covered in the State Plan for Medical Assistance shall be waived. The department shall cover a specified set of benefits for the individuals who are determined to be eligible for this program.

2. Consistent with § 1902(a)(23)(A) of the Act, the participating individuals' freedom of choice of providers of services shall be waived for peer supports and GAP case management.

3. Consistent with § 1902(a)(23) of the Act, the services shall be provided by a different delivery system than otherwise used for full State Plan services for peer supports and GAP case management.

4. Consistent with § 1902(a)(4) of the Act, insofar as it incorporates 42 CFR 431.53 permitting the Commonwealth to waive providing non-emergency transportation to and from participating providers for eligible, participating individuals.

5. Consistent with § 1902(a)(35) of the Act, permitting the Commonwealth to waiver offering eligible, participating individuals retroactive eligibility for this demonstration program.

D. This demonstration program shall operate statewide.

E. This demonstration program shall operate for at least two years beginning January 2015 through January 2017 or until the Commonwealth implements an alternative plan to provide health care coverage to all individuals having incomes up to 100% of the FPL.

F. This demonstration program shall not affect or modify, or both, components of the Commonwealth's existing medical assistance or children's health insurance programs.

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12VAC30-135-430. Individual eligibility; limitations; referrals; eligibility determination process.

A. The GAP eligibility determination process shall have two parts: (i) a determination of whether or not the individual meets the GAP SMI criteria, and; (ii) a determination of whether or not the individual meets the GAP financial and non-financial eligibility criteria.

1. A person may apply through Cover Virginia for GAP by phone or through a provider-assisted web portal.

2. If an individual is found to not meet GAP eligibility rules, either the GAP financial/non-financial criteria or the GAP SMI criteria, then the individual shall be sent an adverse determination letter with appeal rights. Such individuals shall be assessed and referred for eligibility through Medicaid, FAMIS MOMS and the federal marketplace for private health insurance.

B. Individuals shall have a screening conducted by a DMAS-approved GAP screening entity for the determination of eligibility for GAP SMI services.

C. In order to be eligible for this program, individuals shall be assessed to determine whether their diagnosed condition is a serious mental illness (SMI). The serious mental illness shall be diagnosed according to criteria defined in the DSM-5, LMHPs, including LMHP-supervisees, LMHP-residents, LMHP-residents in psychology, shall conduct the clinical screening required to determine the individual's diagnosis if one has not already been made. At least one of the following diagnoses shall be documented for the individual to be approved for GAP SMI services:

1. Schizophrenia spectrum disorders and other psychotic disorders with the exception of substance/medication induced psychotic disorders;

2. Major depressive disorder;

3. Bipolar and related disorders with the exception of cyclothymic disorder;

4. Post-Traumatic Stress Disorder, or;

5. Obsessive compulsive disorder, panic disorder, agoraphobia, anorexia nervosa, or bulimia nervosa.

D. In order to be eligible for this program, individuals shall meet at least one of the following criteria to reflect the duration of illness:

1. Is expected to require treatment and supportive services for the next 12 months;

2. Has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization for a psychiatric condition, more than once in his lifetime; or

3. Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation. A significant disruption of a normal living situation means the individual has been unable to maintain his housing or had difficulty maintaining his housing due to being in a supportive residential facility or program that was not a hospital. This includes group home placement as an adolescent and assisted living facilities but does not include living situations through the Department of Social Services.

E. In order to be eligible for this program, individuals shall demonstrate a significant level of impairment on a continuing or intermittent basis. There shall be evidence of severe and recurrent impairment resulting from mental illness. The impairment shall result in functional limitation in major life activities. Due to the mental illness, the person shall meet at least two of the following:

1. Is either unemployed or employed in a sheltered setting or a supportive work situation; has markedly limited or reduced employment skills, or has a poor employment history;

2. Requires public and family financial assistance to remain in his community;

3. Has difficulty establishing or maintaining a personal social support system;

4. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management; or

5. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

F. The individual shall require assistance to consistently access and to utilize needed medical or behavioral, or both, health services and supports due to the mental illness.

G. In addition, the individuals shall:

1. Be adults ages 21 through 64 years of age;

2. Be U.S. citizens or lawfully residing immigrants;

3. Be residents of the Commonwealth;

4. Be uninsured;

5. Be ineligible for any state or federal full benefits health insurance program including, but not necessarily limited to: Medicaid, Children's Health Insurance Program (CHIP/FAMIS), Medicare or TriCare Federal Military benefits;

6. Have household incomes below 95 percent of the Federal Poverty Level (FPL) plus a five percent household income disregard which shall be verified via pay stubs or other readily available and reliable electronic sources. Pursuant to DMAS federal authority under the § 1115 waiver, should expenditures for the GAP demonstration waiver compromise the program s budget neutrality, DMAS may amend the waiver to maintain budget neutrality by reducing income eligibility levels to below 95% of FPL;

7. Not be a current resident of a long term care facility, mental health facility, or penal institution.

H. Individuals who are enrolled in this GAP demonstration waiver program who require hospitalization shall not be disenrolled from the GAP demonstration waiver program during their hospitalization.

I. If a GAP-eligible individual secures Medicare or Medicaid/FAMIS Moms coverage, his GAP program eligibility shall be terminated consistent with the effective date of the Medicare or Medicaid coverage. Individuals who gain other sources of health insurance shall not be disenrolled from the GAP demonstration waiver program during their 12 months of eligibility; however, in such instances, the GAP program shall be the payer of last resort.

J. DMAS or its contractor shall verify income data via existing electronic data sources, such as Virginia Employment Commission and TALX. Citizenship and identity shall be verified through the monthly file exchange between DMAS and the Social Security Administration. The individuals' age, residency, and insurance status shall be verified through self-attestation. Applicants shall be permitted 90 days to resolve any citizenship discrepancies resulting from Social Security Administration matching process, in any of the information provided and DMAS' or contractor's verification process findings.

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12VAC30-135-440. Individual screening requirements; enrollment process.

A. All individuals who apply for GAP shall be screened by a GAP screening entity using the screening tool (DMAS P-603) and shall meet the requirements of the screening tool. Screenings shall be provided to persons without regard to whether or not they have serious mental illness. Screenings may be either limited or a full screening depending on the individual's prior history of serious mental illness.

B. Two types of screenings shall be conducted:

1. Limited screenings shall be conducted for those individuals who have had a diagnostic evaluation within the past 12 months and this evaluation is available to the screener. These limited screenings may be conducted by either an LMHP or a QMHP.

2. Full screenings shall be conducted for those individuals who have not had a diagnostic evaluation within the past 12 months or for whom the evaluation is not available to the screener. These full screenings shall be conducted by an LMHP.

C. All SMI screenings shall be submitted to the BHSA. The diagnostic evaluation shall be signed and contemporaneously dated by the LMHP who completed it.

D. Once an individual's eligibility has been determined consistent with all of the requirements set out in 12 VAC 30-135-430, his coverage shall become effective on the first day of the same month in which he applied and his signed application has been received. No retroactive eligibility shall be permitted in the GAP SMI demonstration waiver program. No service coverage shall begin prior to the first day of the month that the individual's signed and dated application for the GAP SMI demonstration waiver program is received.

E. Once an individual is determined to be eligible for this GAP demonstration waiver program, his eligibility shall remain effective for 12 continuous months except if the individual becomes 65 years of age, becomes eligible for Medicare or Medicaid, moves out of the Commonwealth, dies, or he is unable to be located.

F. The renewal of an individual's eligibility for this GAP demonstration SMI program shall be re-determined prior to the end of the 12-month coverage period. No additional determination of serious mental illness shall be required to complete a renewal for program eligibility.

G. GAP SMI demonstration program individuals shall not be required to report changes in their financial circumstances during their 12 months coverage period but only at the time of their renewal application.

H. Completion of the application determination process shall require no more than 45 days except in cases of unusual circumstances as described below:

1. Unusual circumstances include: administrative or other emergency beyond the agency's control. In such case, DMAS, or its designee, shall document, in the applicant's record, the reasons for delay. DMAS or its designee shall not use the time standards as a waiting period before determining eligibility or as a reason for denying eligibility because it has not determined eligibility within the time standards.

2. Incomplete applications shall be held open for a period of 45 calendar days to enable applicants to provide outstanding information needed for an eligibility determination. Any applicant who fails to provide, within 45 calendar days of the receipt of the initial application, information or verifications necessary to determine eligibility, shall have his application for GAP SMI eligibility denied.

I. Cover Virginia shall mail approval notices to applicants, including the applicant's identification number, his enrollment period, and a member handbook.

J. The BHSA shall mail out individual's identification cards to the address provided on the individual's application.

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12VAC30-135-450. Covered services; limitations; restrictions.

A. GAP coverage shall be limited to outpatient medical, behavioral health, pharmacy, GAP case management, and care coordination services for individuals determined to meet the GAP SMI eligibility criteria. This program intends that such services will significantly decrease the severity of individuals' serious mental illnesses so that they can recover, work, parent, learn, and participate more fully in their communities.

B. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities.

C. Medical services including outpatient physician and clinic services, specialists, diagnostic procedures, laboratory procedures, and pharmacy services shall be covered as follows:

1. Outpatient physician services and medical office visits includes evaluation and management, and diagnostic and treatment procedures performed in the physician's office, and; therapeutic or diagnostic injections. The requirements of 12 VAC 30-50-140 D 2, 3, 4 shall be met in order for these services to be reimbursed by DMAS.

2. Outpatient clinic services include evaluation and management, treatment, and procedures performed in the clinic's office, and; medically necessary therapeutic and diagnostic injections. The requirements of 12 VAC 30-50-180 B, C, and D shall be met in order for this service to be reimbursed by DMAS as it pertains to GAP covered services.

3. Outpatient specialty care, consultation, management and treatment includes evaluation and treatment, and procedures performed in the physician s office, and; medically necessary therapeutic or diagnostic injections consistent with 12 VAC 30-50-140 D, 2, 3, and 4 as it pertains to GAP covered services.

4. Outpatient diagnostic services includes ultrasounds, electrocardiogram, service-authorized CAT, MRI scans and diagnostic services that can be performed in a physician's office with the exception of colonoscopy procedures and other services listed as non-covered in 12 VAC 30-135-469. The requirements of 12 VAC 30-50-140 (O) shall be met as it pertains to GAP SMI services in order for these services to be reimbursed by DMAS. CAT and MRI scans shall be covered if service authorized by either DMAS or the service authorization contractor.

5. Outpatient laboratory consistent with 12 VAC 30-50-120 as it pertains to GAP SMI covered services.

6. Outpatient pharmacy services are provided consistent with 12 VAC 30-50-210 as it pertains to GAP SMI covered services.

7. Outpatient family planning consistent with 12 VAC 30-50-130 D as it pertains to GAP SMI covered services; sterilization procedures and abortions shall not be covered.

8. Outpatient telemedicine is covered the same as Medicaid for services that are not otherwise excluded from GAP coverage.

9. Outpatient durable medical equipment and supplies coverage shall be limited to diabetic equipment and supplies consistent with 12 VAC 30-50-165 as it pertains to GAP SMI covered services.

10. Outpatient hospital procedures shall be limited to: (i) diagnostic ultrasound procedures; (ii) EKG/ECG including stress tests; (iii) radiology procedures are covered except for PET scans, colonoscopy, and radiation treatment procedures.

11. GAP case management services pursuant to 12VAC30-50-420 as it pertains to seriously mentally ill adults.

a. Reimbursement shall be provided only for "active" case management individuals. An active individual for GAP case management purposes shall mean an individual for whom there is a current ISP, as defined in 12 VAC 30-50-226, that requires regular direct or client-related contacts or activity or communication with the individuals or families, significant others, service providers, or others. Billing can be submitted only for months in which direct or individual-related contacts, activity, or communications occur. Regular case management is reimbursed for months in which the minimum requirements are met for case management. High intensity case management is reimbursed for months in which a face-to-face contact with the individual takes place in a community setting outside of the case management office.

b. The case management entity shall collaborate with the BHSA monthly with care coordination efforts.

c. Case management shall not be billed for persons while they are in institutions for mental disease.

d. The provider of case management services shall be licensed by DBHDS as a provider of case management services.

D. Care coordination, crisis phone line, and peer supports shall be covered through the BHSA as follows:

1. Care coordination shall be provided as defined in 12 VAC 30-135-410. BHSA LMHP care managers shall work closely with behavioral health providers including local CSB staff to provide information to the individual in accessing covered benefits, provider selection, and how to access all services including behavioral health.

2. The BHSA shall provide crisis phone lines twenty-four hours per day and seven days per week including access to a licensed care manager during a crisis.

3. The BHSA or its designee shall provide Peer Support Services seven days per week. A telephonic support shall be covered staffed by PSNs who have been trained specifically in line telephonic support operations and resources. The telephonic support associated with the PSN GAP program shall offer extended hours, toll-free access, and dedicated data collection capabilities. The BHSA shall provide trained peer navigators as members of its care coordination team or may contract with other entities to do so. The BHSA shall employ community-based peer navigators to work in provider settings, community settings, and peer-run organizations. The scope of peer support services shall include, but not be limited to:

a. Visiting members in inpatient settings to develop the peer relationship.

b. Describing and developing a plan for engaging in peer and natural community support resources as part of the recovery process.

c. Initiating rapport, teaching and modeling positive communication skills with members to help them self-advocate for an individualized services plan and assisting the individual with the coordination of services to promote successful community integration strategies.

d. Assisting in developing strategies to decrease or avoid the need for future hospitalizations by offering social and emotional support and an array of individualized services.

e. Providing social, emotional and other supports framed around the eight dimensions of wellness as defined in 12 VAC 30-135-410.

E. Community mental health (behavioral health) services shall be covered as follows:

1. All community mental/behavioral health services shall be subject to service authorization or registration as specified.

2. GAP case management as defined in 12 VAC 30-135-410 shall be provided by CSB case managers with consultation and support from BHSA care managers. This service shall be targeted to individuals who are expected to benefit from assistance with medication management and appropriate use of community resources. The CSB GAP case managers shall have the same knowledge, skills, and abilities as set out in 12 VAC 30-50-420 (E)(2)(e) and the case management entity shall maintain all licenses required by DBHDS in 12 VAC 35-105. GAP case management shall not include the provision of direct treatment services and shall have two levels of service intensity: (i) regular and; (ii) high intensity and shall be focused on assisting individuals to access needed medical, behavioral health (psychiatric and substance abuse treatment), social, education, vocational, and other support services.

3. Crisis intervention shall be covered consistent with the limits and requirements set out in 12 VAC 30-50-226(B)(5) and 12 VAC 30-60-143. This service shall only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified pre-screener. Crisis intervention services shall be indicated following a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

a. The crisis intervention services provider shall be licensed as a provider of Emergency Services by DBHDS pursuant to 12 VAC 35-105-30.

b. An Individual Service Plan (ISP) shall not be required for individuals newly enrolled in GAP services to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

c. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP shall be developed or revised by the fourth face-to-face contact to document the short-term counseling goals.

d. Telephonic supports and collateral contacts related to needs are identified during face-to-face contact.

e. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

f. Crisis intervention services provided to eligible individuals outside of the clinic may be reimbursable, provided the provision of out-of-clinic services is clinically/programmatically appropriate. Travel-related costs (gas and mileage, travel time) by staff to provide out-of-clinic services shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.

g. An LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified prescreener, as defined in 12 VAC 30-50-226, shall conduct a face-to-face service-specific provider intake.

h. Crisis intervention shall be provided by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP or a certified prescreener.

i. Services shall be documented through daily notes and a daily log of time spent in the delivery of services.

4. Crisis stabilization shall be covered consistent with the limits and requirements set out in 12 VAC 30-50-226(B)(7) and 12 VAC 30-60-143 except that service authorization shall be required in place of registration. This service shall only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-E or a certified pre-screener.

a. In order to qualify for crisis stabilization services, individuals shall demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization.

b. This service shall be authorized following a face-to-face service-specific provider intake by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP or a certified prescreener, as defined in 12 VAC 30-50-226.

c. The service-specific provider intake must document the need for crisis stabilization services.

d. Room and board, custodial care, and general supervision are not components of this service and shall not be reimbursed.

e. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

f. Providers of residential crisis stabilization shall be licensed by DBHDS as providers of Mental Health Residential Crisis Stabilization. Providers of community-based crisis stabilization shall be licensed by DBHDS as providers of Mental Health Non-Residential Crisis Stabilization.

5. Psychosocial rehabilitation service-specific provider intake and services shall be covered consistent with the limits and requirements set out in 12 VAC 30-50-226 (B)(4). This service shall only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-E, or a QPPMH. Psychosocial rehabilitation services shall be provided to individuals who have experienced long-term or repeated psychiatric hospitalization, or who experience difficulty in activities of daily living and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.

a. Psychosocial rehabilitation services shall be provided following a service-specific provider intake which clearly documents the need for services. This intake shall be completed by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. An ISP shall be completed by the LMHP, LMHP-supervisee, LMHP-resident, or

LMHP-RP, QMHP-A or a QMHP-E and be reviewed/approved by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 calendar days of service initiation. At least every three months, the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, the QMHP-A or the QMHP-E shall review, modify as appropriate, and update the ISP.

b. The continued need for psychosocial rehabilitation services that continue more than six months shall be reviewed by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP who shall document the continued need for the service.

c. The enrolled provider of psychosocial rehabilitation services shall be licensed by DBHDS as a provider of psychosocial rehabilitation.

d. Psychosocial rehabilitation services may be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A or QMHP-E or a qualified paraprofessional under the supervision of a QMHP-A, QMHP-E or an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

e. The psychosocial rehabilitation program shall operate a minimum of two continuous hours in a 24-hour period.

f. Time allocated for field trips may be used to calculate time and units when the goal of the field trip is to provide training in an integrated setting, and to increase the individual's understanding or ability to access community resources.

F. Outpatient psychotherapy services shall be covered, consistent with 12 VAC 30-50-140 (D)(2), (3), (4) and (5), as follows:

1. Psychiatric evaluation and outpatient individual, family, and group therapies (mental health and substance abuse treatment) shall be covered.

2. The first 26 visits shall be covered without prior authorization and additional visits, beyond the first 26, shall be covered if they have been prior authorized when medically necessity is demonstrated.

3. Reimbursement shall be provided, consistent with 12 VAC 30-80-30(A)(3), in a tiered manner.

G. Community substance abuse treatment services shall be covered as follows:

1. Services shall include intensive outpatient services and opioid treatment services. These services shall be rendered to individuals consistent with the criteria for these two services specified in 12VAC30-50-228(A)(2).

a. Intensive outpatient services for individuals shall be provided in a nonresidential setting and may be scheduled multiple times per week, with a maximum of 19 hours of services per week. This service should be provided to individuals who do not require the intensive level of care of inpatient or residential services, but require more intensive services than outpatient services. Intensive outpatient services shall be provided in a concentrated manner, and generally involve multiple outpatient visits per week over a period of time for individuals requiring stabilization. These services include monitoring, multiple group therapy sessions during the week, and individual and family therapy focused on the enrolled individual. The maximum annual limit is 600 hours. Intensive outpatient services shall not be provided concurrently with day treatment services or opioid treatment services. Even though day treatment services are not covered in the GAP Demonstration SMI program, intensive outpatient services shall not be provided concurrently with it.

b. Pursuant to 12 VAC 30-50-140 (with the exception of § 6403 of the Omnibus Budget Reconciliation Act of 1989 which is excluded), methadone/opioid treatment means an intervention strategy that combines psychological and psycho-educational services with the administering or dispensing of opioid agonist treatment medication. An individual specific, physician-ordered dose of medication is administered or dispensed either for detoxification or maintenance treatment. Methadone/opioid treatment shall be provided in daily sessions with a maximum of 600 hours per year. Intensive outpatient services shall not be provided concurrently with methadone/opioid treatment. Methadone/opioid treatment service covers psychological and psycho-educational services. Medication costs for methadone/opioid agonists shall be billed separately from psychological and psycho-educational services.

c. Staff qualifications for intensive outpatient and opioid treatment services shall be as follows:

(1) The minimum qualification for providing individual and group counseling, family therapy, and occupational and recreational therapy shall be a QSAP.

(2) A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; information about relapse prevention; and occupational and recreational activities. A QSAP shall be onsite when a paraprofessional is providing services.

(3) Paraprofessionals shall participate in supervision as described in 12VAC30-50-228(A)(2)(d).

2. Evaluations required. Prior to initiation of intensive outpatient or opioid treatment services, an evaluation shall be conducted consistent with 12 VAC 30-50-228(B) by at least a QSAP. The minimum intake will consist of a structured objective assessment of the impact of substance use or dependence on the individual's functioning in the following areas: legal system involvement, employment or school performance, or both, and medical, family-social, and psychiatric issues. A psychological and psychiatric examination shall be included as part of this evaluation, if indicated by history or structured assessment.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-135-469. Non-covered medical and behavioral health services.

A. Non-covered medical services shall include:

1. Inpatient hospital treatment including psychiatric facilities and psychiatric facility partial hospitalization;

2. Emergency room treatment;

3. Ambulatory surgical centers;

4. Military treatment facilities;

5. Outpatient hospital procedures other than diagnostic procedures;

6. PET scans

7. Home health;

8. Skilled and intermediate nursing facilities;

9. Long-term care including home and community based care waiver services, custodial care facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities;

10. Residential substance abuse treatment facilities;

11. Psychiatric residential treatment centers;

12. Comprehensive Inpatient/Outpatient Rehabilitation facilities;

13. End-Stage Renal Disease treatment facilities;

14. Hospice;

15. Ambulance (including land, air and water);

16. Early and Periodic Screening Diagnosis and Treatment (EPSDT) services;

17. Dental services;

18. Non-emergency transportation;

19. Physical therapy (PT), occupational therapy (OT), and speech therapies (when billed separately);

20. OB/maternity care including birthing centers (gynecology services are covered);

21. Routine eye exams;

22. Abortions, sterilization (vasectomy or tubal ligation);

23. Chemotherapy, radiation therapy;

24. Colonoscopy;

25. Dialysis;

26. Durable medical equipment (DME) and supply items (other than those required to treat diabetes); orthotics; prosthetics; home IV therapy; nutritional supplements;

27. Cosmetic procedures;

28. Eyeglasses, contact lenses, hearing aids;

29. Private duty nursing;

30. Assisted living;

31. Other unspecified facilities;

32. Services specifically excluded under Virginia Medicaid;

33. Services not deemed medically necessary;

34. Services that are considered experimental or investigational;

35. Services from non-Medicaid-enrolled providers; and

36. Any medical services not otherwise defined as covered.

B. Non-covered traditional behavioral health services shall include:

1. Inpatient hospital or partial hospital services, hospital observation services, emergency room services;

2. Electroconvulsive therapy and related services (anesthesia, hospital charges, etc.);

3. Residential treatment services;

4. Psychological and neuropsychological testing;

5. Smoking and tobacco cessation and counseling;

6. Transportation;

7. Services specifically excluded under Virginia Medicaid;

8. Services not deemed medically necessary;

9. Services that are considered experimental or investigational;

10. Services from non-Medicaid-enrolled providers, and;

11. Any behavioral health or substance abuse treatment services not otherwise defined as covered.

C. Non-covered non-traditional behavioral health services shall include:

1. Substance abuse case management, substance abuse day treatment for pregnant women, substance abuse residential treatment for pregnant women, substance abuse day treatment, substance abuse crisis intervention;

2. Day treatment partial hospitalization, mental health skill building services, intensive community treatment;

3. Treatment foster care case management;

4. VICAP assessments;

5. Transportation;

6. Services specifically excluded under Virginia Medicaid;

7. Services not deemed medically necessary;

8. Services that are considered experimental or investigational;

9. Services from non-Medicaid-enrolled providers, and;

10. Any behavioral health or substance abuse treatment services not otherwise defined as covered.

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12VAC30-135-470. Provider qualifications; requirements.

A. Some GAP covered services require an approved service authorization prior to service delivery in order for reimbursement to occur. Those services are specified in 12 VAC 30-135-450.

1. To obtain service authorization, all providers' information about these individuals which is supplied to the DMAS service authorization contractor, or the behavioral health service authorization contractor shall be fully substantiated throughout individuals' medical records.

2. Providers shall be required to maintain documentation detailing all relevant information about the GAP-enrolled individuals who are in providers' care. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. This documentation shall be written, signed, and dated at the time the services are rendered unless specified otherwise.

B. Providers who are determined not to be in compliance with DMAS' requirements shall be subject to 12VAC30-80-130 for the repayment of overpayments to DMAS.

C. 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 pre-approved 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.

D. An LMHP-Resident in Psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65and 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 pre-approved 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.

E. 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 pre-approved 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.

F. Individualized and member-specific progress notes shall be part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, 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 contemporaneous-with-the-service 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.

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12VAC30-135-475. Individual service plan (ISP) requirements.

A. Individual service plans (ISPs) shall contain all of the elements as set out in 12 VAC 30-135-410. ISPs that do not contain the specified elements shall be considered by DMAS to be incomplete and not adequate to support service reimbursement.

B. Prior to the development of an ISP:

1. A service-specific provider intake shall be completed for the following s3ervices: (i) psychosocial rehabilitation; (ii) crisis intervention, and; (iii) crisis stabilization.

2. An evaluation consistent with 12 VAC 30-50-228(B) shall be completed for substance abuse intensive outpatient and opioid treatment services.

3. DBHDS licensure requirements for assessment and planning as defined in 12 VAC 35-105-650 shall be completed for GAP case management.

C. The ISP shall contain the individual's treatment or training needs, his goals and measurable objectives to meet the individual's identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an 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. Documentation shall be provided if the individual is an adult lacking legal capacity or is unable or unwilling to sign the ISP.

D. The ISP shall be updated at a minimum of annually or as the needs and progress of the individual changes. An ISP shall be considered outdated if it is not updated either annually or as the treatment interventions based on the needs and progress of the individual changes. An ISP that does not include all required elements specified in 12VAC30-50-226 shall be considered incomplete. All ISPs shall be completed, signed, and contemporaneously dated by the LMHP or QMHP who completed the ISP. The preparation of the ISP shall occur within a maximum of 30 days of the date of the completed service-specific provider intake unless otherwise specified. The individual shall sign his own ISP. If the individual is unwilling or unable to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the ISP.

E. Service-specific ISP updating requirements.

1. For individuals receiving psychosocial rehabilitation services, the ISP shall be updated at least every three months by the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, the QMHP-A or the QMHP-E who shall review the ISP and modify it as appropriate.

2. Evaluations shall be required prior to initiation of intensive outpatient or opioid treatment services consistent with 12 VAC 30-50-228(B) by at least a QSAP. The minimum intake will consist of a structured objective assessment of the impact of substance use or dependence on the individual's functioning in the following areas: legal system involvement, employment or school performance, or both, and medical, family-social, and psychiatric issues. A psychological and psychiatric examination shall be included as part of this evaluation, if indicated by history or structured assessment. The assessment shall result in a written report as specified at 12VAC30-50-228(B)and shall document the medical necessity for either the intensive outpatient service or methadone/opioid treatment, or both.

3. The ISP shall document the need for GAP case management and be fully completed within to calendar days of initiation of the service. The case manager shall review the ISP at least monthly. The review shall be due by the last day of the month following the month in which the last review was completed.

4. The ISP shall be updated at least annually.

5. For crisis stabilization services, the ISP shall be developed or revised within three calendar days of admission to this service. The LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, certified prescreener, QMHP-A or QMHP-E shall develop the ISP.

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12VAC30-135-480. Utilization review.

A. These utilization requirements shall apply to all GAP covered services unless otherwise specified.

B. DMAS, or its designee, shall perform reviews of the utilization of all GAP-covered services pursuant to 42 CFR 440.260 and 456.1 et seq.

C. DMAS shall recover expenditures made for covered services when providers' documentation does not comport with standards specified in state and federal Medicaid requirements.

D. Utilization reviews shall include determinations that providers meet the following requirements:

1. The provider shall meet the federal and state requirements for administrative and financial management capacity. The provider shall obtain a current Provider Enrollment Agreement that covers each GAP service that the provider offers, prior to the delivery of services, and shall maintain and update the Agreement periodically as DMAS or its contractor requires. DMAS shall not reimburse providers who do not enter into a Provider Enrollment Agreement for a service prior to offering that service.

2. The provider shall document and maintain individual case records in accordance with state and federal Medicaid requirements.

3. The provider shall ensure eligible individuals have free choice of providers of behavioral health services and other medical care.

4. If an individual receiving community mental health rehabilitative services or substance abuse treatment services is also receiving case management services pursuant to 12VAC30-50-420, the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the case manager within 30 calendar days of the discontinuation of services. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

5. The provider shall determine who the primary care provider is and inform him of the individual's receipt of GAP community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's condition requires assistance for participation in treatment, assistance shall be provided.

E. Utilization review requirements specific to community mental health services, as set out in 12VAC30-50-226, 12 VAC 30-60-140 and 12 VAC 30-60-143, shall be as follows:

1. To be reimbursed for GAP behavioral health services, the required DBHDS license shall be either a full, annual, triennial, or conditional license. Providers shall be enrolled with the BHSA to be reimbursed. Once enrolled, a provider shall maintain, and update periodically as the BHSA requires, a current Provider Enrollment Agreement for each GAP service that the provider offers.

2. Health care entities with provisional licenses shall not be reimbursed as GAP providers of community mental health services.

3. Payments shall not be permitted to health care entities who fail to enter into a Provider Enrollment Agreement for a service prior to rendering that service.

4. The behavioral health service authorization contractor shall apply the appropriate medical necessity criteria for community mental health services covered by GAP as defined in 12 VAC 30-50-226. Services that fail to meet medical necessity criteria shall be denied service authorization.

F. Individualized and individual-specific progress notes shall be part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and as appropriate, 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 contemporaneous-with the service 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 unique progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

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12VAC30-135-485. Reimbursement.

A. All services covered in the GAP program shall be billed and reimbursed through the existing Medicaid/CHIP fee-for-service methodology and claims process.

B. Specific covered services shall require service authorization via the department's and BHSA requirements.

C. Reimbursement for substance abuse services shall be consistent with 12 VAC 30-80-32 (1), (2), (3), (4), (5), and (6).

D. Service authorization shall not guarantee payment for the service.

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12VAC30-135-487. Client appeals.

A. Notwithstanding the provisions of 12VAC30-110-10 through 12VAC30-110-370, the following regulations for client appeals, 12 VAC 30-135-487 through 12 VAC 30-135-495, govern state fair hearings for GAP program applicants and enrolled individuals. Appeal procedures for GAP providers are set out in 12 VAC 30-135-496.

B. GAP program applicants and enrollees (also referred to as appellants) shall have the right to a hearing pursuant to 42 CFR § 431.220.

C. Applicants and enrollees shall be notified in writing of the appeals process at the time of the request for eligibility, and upon receipt of a notice of action from Cover Virginia, BHSA, or the service authorization contractor.

D. An appellant shall have the right to representation by an attorney or other individual of his choice at all stages of an appeal.

1. For those appellants who wish to have a representative, a representative shall be designated in a written statement which is signed by the appellant whose Medicaid benefits were adversely affected. If the appellant is physically unable to sign a written statement, the division shall allow a family member or other person acting on the appellant's behalf to be the representative. If the appellant is mentally unable to sign a written statement, the division shall require written documentation that a family member or other person has been appointed or designated as his legal representative.

2. If the representative is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant, prepared on the attorney's letterhead, shall be accepted as a designation of representation.

3. A member of the same law firm as a designated representative shall have the same rights as the designated representative.

4. An appellant may revoke representation by another person at any time. The revocation is effective when the department receives written notice from the appellant.

E. Any written communication from an applicant or enrollee or his representative which clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request.

1. This communication should explain the basis for the appeal of Cover Virginia or the service authorization contractors action.

2. The applicant or enrollee or his representative, may examine witnesses or documents, or both, provide testimony, submit evidence, and advance arguments during the hearing.

F. Appeals to the state fair hearing process shall be made to the DMAS Appeals Division in writing, with the exception of expedited appeals, and may be made via US Mail, fax transmission, hand-delivery or electronic transmission.

G. The agency of record, Cover VA, BHSA, or the service authorization contractor, shall attend and defend their decisions at all appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS' Appeals Division. Travel and telephone expenses in relation to appeal activities shall be borne by the agency of record, Cover VA, or the service authorization contractor, as appropriate.

H. Expedited appeals referenced in 12VAC30-135-487 (K) below may be filed by telephone, or by any of the methods set forth in subsection F in this subdivision.

I. The BHSA, or the service authorization contractor shall continue benefits while the appeal is pending when all of the following criteria are met:

1. The applicant or enrollee or his representative files the appeal within 10 calendar days (plus five mail days) of the date the notice of action was sent by Cover Virginia, BHSA, or the service authorization contractor.

2. The appeal involves the termination, suspension, or reduction of eligibility benefits or a previously authorized course of treatment;

3. In the case of services, the services were ordered by an authorized provider, and the original period covered by the initial authorization has not expired; and

4. The applicant or enrollee or his representative requests continuation of benefits.

J. After the final resolution and if the final resolution of the appeal is adverse to the enrollee (e.g., Cover Virginia, BHSA, or the service authorization contractor s action is upheld), the agency may recover the costs of services furnished to the applicant or enrollee while the appeal was pending, to the extent they were furnished solely because of the pending appeal.

K. The Department shall maintain an expedited process for appeals when an appellant s or enrollee's treating provider certifies that taking the time for a standard resolution could seriously jeopardize the appellant's or enrollee s life or health or ability to attain, maintain or regain maximum function. Expedited appeal decisions shall be issued as expeditiously as the appellant's or enrollee s health condition requires.

1. For eligibility matters, the Commonwealth shall render appeal decisions within a reasonable amount of time. In setting time frames, the Commonwealth shall consider the need for expedited appeals when there is an immediate need for health services.

2. For health services matters, the Commonwealth shall ensure that appeals that meet the criteria for expedited resolution are completed no later than 72 hours after the agency receives a fair hearing request.

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12VAC30-135-489. Appeal timeframes.

A. Appeals to the Medicaid state fair hearing process shall be filed with the DMAS Appeals Division within 30 days of the date the notice of action was sent by Cover Virginia, BHSA, or the service authorization contractor, unless the time period is extended by DMAS upon a finding of good cause in accordance with state fair hearing regulations.

B. It is presumed that appellants or enrollees will receive the notice of action five days after Cover Virginia, BHSA, or the service authorization contractor mails it, unless the appellant shows that he did not receive the notice within

the five-day period. For purposes of calculating the five-day period, it is presumed that the notice was mailed by Cover VA, BHSA, or the service authorization contractor on the date that is indicated on the notice.

C. A request for appeal on the grounds that Cover Virginia, BHSA, or the service authorization contractor has not acted with reasonable promptness in response to an eligibility or service request may be filed at any time until Cover Virginia or the service authorization contractor has acted.

D. The date of filing shall be the date the request is postmarked, if mailed, or the date the request is received by the department, if delivered other than by mail.

E. Documents postmarked on or before a time limit's expiration shall be accepted as timely.

F. In computing any time period under these regulations, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.

G. An extension of the 30-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include, but are not limited to, the following situations:

1. The appellant or enrollee was seriously ill and was prevented by illness from contacting the Department;

2. The notice of action completed by Cover Virginia, BHSA, or the service authorization contractor was not sent to the appellant. Cover Virginia or the service authorization contractor may rebut this claim by evidence that the decision was mailed to the appellant's or enrollee's last known address or that the notice was received by the appellant;

3. The appellant or enrollee sent the request for appeal to another government agency in good faith within the time limit; or

4. Unusual or unavoidable circumstances prevented a timely filing of the appeal request.

H. Appeals shall be heard and decisions issued within 90 days of the postmark date (if delivered by US mail) or receipt date (if delivered by any method other than US mail).

I. Exceptions to standard appeal resolution timeframes. Decisions may be issued beyond the standard timeframe when the appellant/enrollee/representative requests or causes a delay. Decisions may also be issued beyond the standard appeal resolution timeframe when any of the following circumstances exist:

1. The appellant, enrollee, or representative requests to reschedule/continue the hearing.

2. The appellant, enrollee, or representative provides good cause for failing to keep a scheduled hearing appointment, and the Appeals Division reschedules the hearing.

3. Inclement weather, unanticipated system outage, or the Department's closure that prevents the hearing officer's ability to work;

4. Following a hearing, the hearing officer orders an independent medical assessment as described in 12VAC30-110-200.

5. The hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant, enrollee, or representative.

6. The hearing officer receives additional evidence from a person other than the appellant, enrollee, or his representative, and the appellant, enrollee, or representative requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence OR;

7. The Appeals Division determines that there is a need for additional information, and documents how the delay is in the Appellant s interest.

J. For delays requested or caused by an appellant, enrollee or his representative, the delay date for the decision will be calculated as follows:

1. If an appellant, enrollee, or representative requests or causes a delay within 30 days of the request for a hearing, the 90-day time limit will be extended by the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

2. If an appellant, enrollee, or representative requests or causes a delay within 31 to 60 days of the request for a hearing, the 90-day time limit will be extended by 1.5 times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

3. If an appellant, enrollee, or representative requests or causes a delay within 61 to 90 days of the request for a hearing, the 90-day time limit will be extended by 2 times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

K. Post hearing delays requested or caused by an appellant, enrollee, or representative (e.g. requests for the record to be left open) will result in a day for day delay for the decision date. The Department shall provide the appellant, enrollee, and representative with written notice of the reason for the decision delay and the delayed decision date, if applicable.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-135-491. Prehearing decisions.

A. If the Appeals Division determines that any of the conditions exist as described below, a hearing shall not be held and the appeal process shall be terminated.

1. The appeal request was not filed within the time limit imposed by 12VAC30-110-60 or extended pursuant to 12VAC30-110-170. The appellant, enrollee, or representative did not reply to the hearing officer's request for an explanation that met good cause criteria.

2. The individual who filed the appeal is not the appellant and has not submitted authorization to represent the appellant under the provisions of 12VAC30-110-60.

3. Subsequent to the appeal request, the appellant's or enrollee's eligibility or request for services was approved for the full amount, duration and scope of the services requested.

4. The appellant, enrollee, or representative failed to appear at the scheduled hearing and the appellant, enrollee, or representative did not reply to the hearing officer's request for an explanation that met good cause criteria.

5. A written notice of the telephonic hearing has been agreed to by the appellant and sent to the appellant, but the appellant or his representative has failed to respond to the hearing officer's request for a telephone number at which he could be reached for the telephonic hearing.

6. The appellant, enrollee, or representative withdrew the appeal request.

7. The sole issue is a Federal or State law requiring an automatic change adversely affecting some or all appellants or enrollees.

8. The hearing officer determined from the record, without conducting a hearing, that Cover VA or the service authorization contractors action was clearly in error and that the case should be resolved in the appellant's or enrollee's favor. The hearing officer may issue a decision pursuant to 12VAC30-110-210 C.

B. A letter shall be sent to the appellant, enrollee, or representative that explains the determination made on his appeal.

C. If the hearing officer determines from the record that the actions of Cover VA, the BHSA, or the service authorization contractor were clearly in error and that the case should be resolved fully in the appellant's favor, then the hearing officer may issue a decision pursuant to 12VAC 30-110-210 C without conducting a hearing.

D. If the hearing officer determines from the record, without conducting a hearing, that the case might be resolved in the appellant's favor, if Cover VA, the BHSA, or the service authorization contractor obtains or develops additional information, documentation, or verification, then the hearing officer may remand the case to Cover VA, the BHSA,

or the service authorization contractor for action consistent with the hearing officer's written instructions pursuant to 12 VAC 30-110-210 D.

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12VAC30-135-494. Evidentiary hearings and final decisions.

A. All hearings shall be scheduled at a reasonable time, date, and place and the appellant and his representative shall be notified in writing at least 15 days before the hearing.

1. The hearing location shall be determined by the Appeals Division.

2. A hearing shall be rescheduled at the appellant s request no more than twice unless compelling reasons exist.

3. Rescheduling the hearing at the appellant s, enrollee's, or representative's request will result in automatic waiver of the 90-day deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-135-489(J).

B. The hearing shall be conducted by one or more hearing officers or other impartial individuals who were not directly involved in the initial determination of the action in question. The hearing officer or officers shall review the complete record for all Cover Virginia, BHSA, or service authorization contractor actions which are properly appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; research the issues, and render a written final decision.

C. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeal record shall be made accessible to the appellant and representative at a convenient place and time before the date of the hearing, as well as during the hearing. The appellant or enrollee and his representative may examine the content of the appellant's or enrollee's case file and all documents and records the Department will rely on at the hearing except those records excluded by law.

D. Appellants, enrollees, or representatives who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request in writing the issuance of a subpoena. The request must be received by the Department at least 10 working days before the scheduled hearing. Such request shall include the witness' or respondent s name, home and work addresses, county or city of work and residence, and identify the sheriff's office which will serve the subpoena.

E. The hearing officer shall conduct the hearing, decide on questions of evidence, procedure and law, question witnesses, and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in or observe the hearing.

F. Hearings shall be conducted in an informal, non-adversarial manner. The appellant, enrollee, or his representative shall have the right to bring witnesses, establish all pertinent facts and circumstances; present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine agency representatives.

G. The rules of evidence shall not strictly apply. All relevant, non-repetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

H. The hearing officer may leave the hearing record opened for a specified period of time after the hearing in order to receive additional evidence or argument from the appellant or his representative.

1. The hearing officer may order an independent medical assessment when the appeal involves medical issues such as a diagnosis, an examining physician's report, or a medical review team's decision; and the hearing officer determines that it is necessary to have an assessment by someone other than the person or team who made the original decision (e.g., to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence). A medical assessment ordered pursuant to this regulation shall be at the Department's expense and shall become part of the record.

2. The hearing officer may receive evidence that was not presented by either party if the record indicates that such evidence exists, and the appellant, or his representative, requests to submit it or requests that the hearing officer secure it.

3. If the hearing officer receives additional evidence from an entity other than the appellant, enrollee or his representative, the hearing officer shall send a copy of such evidence to the appellant, enrollee and his representative, and give the appellant, enrollee or his representative the opportunity to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence.

4. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether or not it will be used in making the decision.

I. After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision which either sustains or reverses the action of Cover Virginia or the service authorization contractor, or remands the case for further evaluation consistent with his written instructions. Some decisions may be a combination of these dispositions. The hearing officer's final decision shall be considered as the Department's final administrative action pursuant to 42 CFR § 431.244(f). The final decision shall include:

1. Identification of the issue or issues;

2. Relevant facts, to include a description of the procedural development of the case;

3. Conclusions of law, regulations and policy that relate to the issue or issues;

4. Discussions, analysis of the accuracy of the agency s decision, conclusions and hearing officer's decision;

5. Further action, if any, to be taken by the agency to implement the decision;

6. The deadline date by which further action must be taken; and

7. A cover letter informing the appellant and representative of the hearing officer's decision. The letter must indicate that the hearing officer's decision is final, and that the final decision may be appealed directly to the Circuit Court.

J. A copy of the hearing record shall be forwarded to the appellant, enrollee and his representative with the final decision.

K. An appellant or enrollee who disagrees with the hearing officer's final decision as defined herein may seek judicial review pursuant to the Administrative Process Act (§ 2.2-4026of the *Code of Virginia*) and Rules of the Supreme Court of Virginia, Part Two A. Written instructions for requesting judicial review must be provided to the appellant, enrollee or representative with the hearing officer's decision, and upon request by the appellant, enrollee or representative.

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12VAC30-135-495. Division appeal records.

A. No person shall take from the division's custody any original record, paper, document, or exhibit which has been certified to the division except as the Appeals Division Director or his designee authorizes, or as may be necessary to furnish or transmit copies for other official purposes.

B. Information in the appellant's or enrollee's record can be released only to the appellant, enrollee, his authorized representative, the agency, other entities for official purposes, and other persons named in a release of information authorization signed by an appellant or his representative.

C. The fees to be charged and collected for any copies of division records will be in accordance with Virginia's Freedom of Information Act (§ 2.2-3700 *et seq*. of the *Code of Virginia*) or other controlling law.

D. When copies are requested from records in the division's custody, the required fee shall be waived if the copies are requested in connection with an enrollee's own appeal.

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12VAC30-135-496. Provider appeals.

A. The department s Appeals Division maintains an appeal process for enrolled GAP providers of GAP services who have rendered services and are requesting to challenge an adverse decision. The appeal process is available to (i) enrolled GAP service providers that have rendered services and have received a denial in whole or part for GAP covered services, and (ii) enrolled GAP service providers who have received a Notice of Program Reimbursement or overpayment demand from the department or its contractors.

B. Unless otherwise specified above, department provider appeals shall be conducted in accordance with the Department's provider appeal regulations at 12VAC30-20-500 *et. seq*. the *Code of Virginia* at § 32.1-325 *et. seq*. and the Virginia Administrative Process Act § 2.2-4000*et. seq*.

C. The department's appeal decision shall be binding on Cover VA, the BHSA and the service authorization contractor and shall not be subject to further appeal.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-135-498. Individual rights.

A. Individuals who have been found eligible for this GAP program shall have the right to be treated with respect and dignity by health care providers' staff and their personal health information kept in confidence per the Health Insurance Portability and Accountability Act.

B. No premiums, copayments, coinsurance or deductibles shall be charged to individuals who have been found to be eligible for the GAP program.