townhall.virginia.gov

Final Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-50 and 12 VAC 30-60
Regulation title(s)	Amount, Duration, and Scope of Services for Categorically Needy and Medically Needy Individuals; Standards Established and Methods Used to Assure High Quality of Care
Action title	Mental Health Skill-Building Services
Date this document prepared	2/11/2016

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

DMAS is finalizing emergency regulations that re-name and re-define the currently covered Mental Health Support Services to Mental Health Skill-building Services (MHSS) in order to emphasize the rehabilitative nature that DMAS always intended this service to have. This service was never intended to be interpreted as long-term companion care, or community social assistance. DMAS is also finalizing specific criteria that were present in the emergency regulations for what requirements individuals must meet in order to be approved to receive this service.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

ALF = Assisted Living Facility
BHSA = Behavioral Health Services Administrator
CMHRS = Community Mental Health Rehabilitative Services
CSB = Community Services Board
DBHDS = Department of Behavioral Health and Developmental Services
DMAS = Department of Medical Assistance Services
ISP = Individualized Service Plan
LMHP = Licensed Mental Health Professional
LMHP –R = Licensed Mental Health Professional Resident
LMHP –RP = Licensed Mental Health Professional Resident in Psychology
LMHP –S = Licensed Mental Health Professional Supervisee
MHSS = Mental Health Skill-building Service
NOIRA = Notice of Intended Regulatory Action
QMHP-A= Qualified Mental Health Professional, Adult
QMHP-C = Qualified Mental Health Professional, Child
QMHP-E = Qualified Mental Health Professional, Eligible

Statement of final agency action

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

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages, entitled Mental Health Skill-building Services and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

February 11, 2016
Date

____/signature/_____
Cynthia B. Jones, Director
Dept. of Medical Assistance Services

Legal basis

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

These final regulations are being promulgated following Emergency Regulations which were in place from October 10, 2013 to October 9, 2015.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The 2012 *Acts of the Assembly*, Chapter 3, Item 307 LL directed DMAS to make programmatic changes in Community Mental Health Rehabilitative Services and to consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. DMAS was directed to promulgate regulations to implement these changes. In response, DMAS promulgated emergency regulations for this issue.

Pursuant to the 2012 *Acts of Assembly,* Chapter 3, Item 307 RR (f) directed DMAS to implement a mandatory care coordination model for Behavioral Health Services. The goals of Item 307 RR (e) include the achievement of cost savings and simplification of the administration of Community Mental Health Rehabilitative Services through the use of the Behavioral Health Services Administrator. Item 307 RR (f) authorizes DMAS to promulgate emergency regulations for this mandatory model.

Pursuant to the *2013 Acts of Assembly*, Chapter 806, Item 307 DD, DMAS was directed to implement service authorization and utilization review for community-based mental health rehabilitative services for children and adults. Mental health skill-building services is one of the included services.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The Medicaid covered service that is affected by this action is Mental Health Support Services (MHSS) renamed Mental Health Skill-building Services to better reflect the intent of the service. DMAS always intended this service to have a rehabilitative focus and defined it as training and supports to enable individuals to achieve and maintain stability and independence in their communities. Providers misunderstood DMAS' intent and MHSS evolved into services other than rehabilitation. This has contributed to the $138 M increase in expenditures for this service. Most of this expenditure increase has been attributed to adult Medicaid individuals. This service was not intended to be a stand-alone service, but rather to be coupled with other services that the target population would most likely benefit from, but it has been used to provide a wide variety of interventions. Stakeholders note that this service has been used to provide crisis intervention, counseling/therapy, transportation, recreation, and of significant concern, companion-like services, and general supervision.

DMAS' goal is that individuals receive the correct level of service at the correct time for the treatment (service) needs related to the individual's medical/psychiatric condition. Community mental health rehabilitative services (CMHRS) are behavioral health interventions and are intended to provide clinical treatment to individuals with serious mental illness or children with, or at risk of developing, serious emotional disturbances. Clinical treatment differs from community social assistance and/or child welfare programs in that behavioral health services are designed to provide treatment for a mental illness rather than offer assistance for hardship due to socio-economic conditions, age, or physical disability. Stakeholders' feedback supported, and DMAS' observations concluded, that MHSS would continue straying from its intent into a social service level of support rather than remain a psychiatric treatment modality, if regulatory changes were not made.

In this action, DMAS intends to finalize eligibility criteria, service definitions, and reimbursement requirements that were initially in place in the emergency regulations.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both.

The sections of the State Plan for Medical Assistance that are affected by this action are: the Amount, Duration, and Scope of Services (12 VAC 30-50-226) and Standards Established and Methods Used to Assure High Quality of Care (12 VAC 30-60-143).

Currently, Chapter 50 (section 226) sets out the coverage limits for Community Mental Health Rehabilitative Services, which includes day treatment/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT) and mental health support services.

CURRENT POLICY

Prior to the implementation of the emergency regulations, Mental Health Support Services (MHSS) was defined as a Medicaid community mental health treatment service with a rehabilitative focus and defined as goal-directed training to enable individuals to achieve and maintain stability and independence in their communities in the most appropriate, least restrictive environments. Prior to the emergency regulation, MHSS included the following components:

- Training in the performance of activities of daily living in the least restrictive environment to achieve and maintain community stability and independence;
- Training about medication management; and
- Monitoring of health, nutrition, and physical condition.

ISSUES

In the past, individuals who have not been diagnosed with either a serious mental illness or serious emotional disturbance have accessed Medicaid's MHSS. DBHDS' licensing specialists and DMAS auditors reported that MHSS services had become more like companion care and less like mental health skills training with a rehabilitative and maintenance focus.

Based on public comments during the NOIRA comment period, DMAS believes that some providers billed this service for reimbursement when the service actually rendered involved driving the individual to medical appointments (sometimes over long distances) and remaining with the individual to later return home. Neither transportation nor companion services were ever intended to be covered as part of MHSS. If a MHSS provider transports an individual, the provider may only bill for MHSS if skill-building training takes place for the entire time. Direct time spent with the individual is billable to DMAS as long as training in skills related to resolving functional limitations deriving directly from mental illness occurs during the entire time that is billed. Medicaid already provides transportation to medical appointments via its contract with a transportation vendor.

RECOMMENDATIONS

The intent of this service has always been to provide mental health skills training to individuals, who have severe, chronic mental illness or emotional disturbances, so that they can successfully and independently live in their communities in the least restrictive environments possible. To help resolve the discrepancy between the intent of the service and the way in which it was being provided, DMAS changed the service's name to 'Mental Health Skill-building Service' to emphasize the rehabilitative nature of the service.

The regulatory changes also seek to implement the service eligibility criteria for MHSS that were contained in the emergency regulations. DMAS will continue to direct individuals who previously received non-skill building interventions via this service, to more appropriate resources that can meet non-skill-building needs; i.e., social services, crisis intervention, case management, etc.

The regulations also implement overlaps of MHSS with other similar services, as duplicative and not therapeutically beneficial. For example, MHSS will not be available to individuals who are also receiving in-home residential services or congregate residential services provided through the Intellectual Disability or Individual and Family Developmental Disability Support home and community based waivers.

Similarly, MHSS will not be available to individuals who are receiving Treatment Foster Care or independent living services through programs offered by the Department of Social Services or the Office of Comprehensive Services. Any overlap in these services with MHSS is considered duplicative and clinically ineffective.

The regulations also continue the reduction that may be provided in an assisted living facility and Level A or Level B group homes. This ensures that MHSS is not duplicative of services that are already being provided in residential placements, such as assistance with medication management. The regulations permit providers to offer half of each week's authorized MHSS hours to ALF/group home residents outside of their residential setting. This requirement is

intended to assist with training individuals to achieve and maintain community stability and independence. The regulations also specify that MHSS may not be provided to residents of Intermediate Care Facilities for Individuals with Intellectual Disability or hospitals to prohibit inappropriate overlaps of MHSS with these providers.

MHSS may be provided to nursing facility residents during the last 60 days of the nursing facility stay. The service may be reauthorized once for another 60 days, only if discharge to the community is being developed. This allows individuals to access MHSS when transitioning from a nursing facility into an independent living arrangement. This new limitation also prevents individuals who remain in a nursing facility on a long-term basis from accessing MHSS, because they do not require training in community independent living skills. In order for individuals in residential treatment facilities to transfer to their communities, the MHSS assessment may be performed in the last seven days before discharge allowing service onset upon discharge.

The regulations seek to improve the quality of the services provided by ensuring that MHSS providers communicate important information to other healthcare professionals who are providing care to the same individuals. In the past, there has been very little communication with other health care practitioners, and virtually no communication with prescribing physicians.

These regulatory changes seek to bridge this gap. For example, if an individual who receives MHSS under the new criteria fails to adhere to his prescribed medication regimen, it could have a significant, negative impact on the individual's mental health. If a paraprofessional providing MHSS to an individual learns of the non-adherence to the prescribed medication regimen, he is now required to notify his or her supervisory staff. Supervisory staff is also being required to communicate this information to the individual's treating physician, so that he or she is aware of the problem and therefore is able to address it at the next visit.

CHANGES BETWEEN EMERGENCY AND FINAL STAGE:

The chart below shows the regulatory changes in phases from 2013 through 2015:

Regulation Section	12VAC30-50-226	12VAC30-60-143
10/10/2013 Regulation change Followed by Medicaid Memo dated 10/31/2013	Changed Name to Mental Health Skill-building Services, Extensive revision of the medical necessity criteria ensure services are provided to persons with serious mental health disorders and significantly defined service histories, both of which are required to qualify for the program. Required assessment of training needs and the provision of training services in the services plan to qualify for reimbursement.	Requires providers of MHSS to be licensed as an MHSS provider, eliminated the recognition of Supportive In Home and Intensive and Assertive Community Treatment licenses, Requires that service plans and initial and ongoing assessments be conducted by an LMHP, Disallowed MH Supports Providers from being provided by the Group Home or Assisted Living Facility agency where the member resides. Limited the allowance of MHSS to persons receiving various Medicaid Waiver services. Excluded certain diagnoses including delirium, dementia and other cognitive disorders from receiving services.

2014 Proposed Final Regulation changes prior to public comment period	Limit the number of service hours per year to 1300 per member. Requires Crisis Stabilization assessments to be completed by an LMHP. Requires Crisis Stabilization providers to be licensed as a Crisis Stabilization provider and use an LMHP for all assessments and clinical supervision; Limits allowable supports and training to IADLS with goal directed service plans; Allow members to have received either residential or non-residential crisis intervention services as part of their prior service history. Requires service authorization instead of registration for crisis intervention and crisis stabilization services.	Limit the number of units that may be provided to residents of an ALF or Group Home to 1200 hours per year, Moved some exclusion criteria to the eligibility section in 12VAC30-50-226 to better clarify exclusions to eligibility. Requires service authorization instead of registration for crisis intervention and crisis stabilization services.
2015 Final Regulation changes after the public comment period of 8/24/2015-10/23/2015	Removed reference to service authorization for crisis services. Clarified the timeliness requirements in the crisis intervention and crisis stabilization registration process. Changed the MHSS providers who are allowed to develop the ISP to match the standard for adult CMHR services which includes the QMHP types in addition to the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. Corrected unit values for MHSS, adjusted service limits to match new unit values. Changed MHSS to no longer require a service specific provider intake every six months, that function was replaced with a "service review" by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP to ensure the individual continues to meet medical necessity criteria.	Clarified the timeliness in the crisis intervention and crisis stabilization registration process. Clarified timeliness standards for documenting the ISP review. Adjusted the MHSS annual maximum number of units allowed to match the new daily and weekly service limits. Replaced the incorrect listing of 15 minute unit values and their respective maximum allowances with maximum limitations that match the MHSS unit values defined in 12VAC30-50-226. Changed the provider requirements for developing the ISP to allow an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E to develop the ISP. Adjusted the MHSS documentation requirement for the ISP review to match the ISP review definition.
Reimbursement Changes	None, clarified unit value.	Adjusted the MHSS unit values to conform to the same unit values as defined in 12VAC30-50-226.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

Aside from reduced expenditures for MHSS, the primary advantage to the Commonwealth for these changes, is that individuals receiving these services will make functional gains and achieve enhanced tenure in their communities. Service providers are now uniformly required to use a more stringent provider licensing criteria to guide service provision and must use direct-service

staff with clinical and educational backgrounds and experience. The focus on skills training is individualized and is required to be more evidence based, potentially yielding more substantial long term benefits to the individual receiving the MHSS service. The new model has resulted in fiscal savings by implementing enhanced program requirements and medical necessity criteria. MHSS is now more cost effective to provide with more opportunities for oversight of program effectiveness than previously available. There are no disadvantages to the Commonwealth if these changes are accepted as final regulations. The MHSS changes provide a more efficient use of Commonwealth general funds.

Initial Stakeholder Impressions of Impact

- Stakeholders reported an emotional impact to family members and caregivers if services were discontinued. They also described several case examples where individuals who did not meet the new MHSS level of service had few options for other services. In addition, they reported that a service such as peer supports would be beneficial for this population.
- The stakeholder group also reported a few individuals who experienced some instances of hospitalizations after their discharge from MHSS. However, from the examples and an analysis of service data, a direct correlation between loss of MHSS and an increase in hospitalizations is not observed.
- Stakeholders expressed a variety of concerns about how the changes to the MHSS medical necessity criteria have produced a service that is more difficult to staff. Providers stated that the DBHDS MHSS license (which is required by DMAS) limited their ability to use individuals with different educational backgrounds as providers.
- Providers report a more cumbersome intake assessment procedure to document the new eligibility requirements.
- The VACSB reported that during 2014 the CSB system has lost staffing due to the eligibility changes for MHSS and the resulting reduction in revenue.

Conclusion

MHSS regulatory changes made in December 2013 to address program integrity and cost effectiveness concerns appear to be reducing the number of individuals who are inappropriately using the service and related expenditures. Since the changes took effect, the average number of persons receiving MHSS decreased to approximately 10,800 per month compared to 14,800 per month prior to December 2013. This number is now close to the average number of people who were being served prior to the dramatic growth that began after 2009.

The revised medical necessity criteria created a service that is targeted exclusively to a higher needs population. The MHSS workgroup achieved its goal of returning the program to its original intended purpose, which was to serve individuals with severe mental illness to help them safely remain in the community.

Stakeholders expressed a desire for DMAS to develop a new service to address a gap in services resulting from the revised service eligibility criteria. The availability of a lower level of care such as peer supports was recommended for adults who meet the diagnostic criteria and demonstrate significant functional impairments yet may not qualify for the MHSS level of care.

DMAS introduced budget language to promulgate regulations to cover peer supported services that will be considered during the 2016 General Assembly. DMAS is actively pursuing other initiatives to transform service delivery and to enhance the system of care to better meet the needs of Virginia's most complex populations.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements more restrictive than federal requirements in these regulations.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No localities are uniquely affected by these recommended regulatory changes as these policies will uniformly apply statewide.

Family Impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment

Changes made since the proposed stage

*Please list all changes that made to the text of the proposed regulation and the rationale for the changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. *Please put an asterisk next to any substantive changes.*

Section number	Requirement at Proposed/Emergency stage	What has changed	Rationale for change
12VAC30-50-226	All services which do not require service authorization require registration.	Removed reference to service registration.	All services defined in the covered services portion of this regulation package require a service authorization to authorize payment.
12VAC30-50-226	Crisis Intervention required registration within one business day of the provider's completion of their intake. Crisis Stabilization required registration within one calendar day of the provider's intake.	Clarified the timeliness requirements in the crisis intervention and crisis stabilization service authorization process.	The current regulations require registration but the timeliness requirements are different between crisis intervention and crisis stabilization. The change gives the two services consistent timeliness requirements.
12VAC30-50-226	The LMHP-, LMHP-Resident, LMHP-Supervisee shall complete, sign, and date the ISP within 30 days of the admission to this service.	Changed the MHSS providers who are allowed to develop the ISP to match the standard for adult CMHR services which includes the QMHP types in addition to the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.	This requirement was mistakenly limiting ISP development to only the LMHP, LMHP-supervisee or LMHP-resident staff. It was amended to align with other adult oriented provider requirements.
12VAC30-50-226	d. Effective July 1, 2014, the yearly limit for mental health skill-building services is up to 1300 units per fiscal year. The weekly limit for mental health skill-building services is up to 25 units for those individuals who are not residing in assisted living facilities or group homes (Level A or B). The daily limit is a maximum of five units. Only direct face-to-face contacts and services to the individual shall be reimbursable. Prior to July 1, 2014, the previous limits shall apply. e. Effective July 1, 2014, one unit shall be defined as one hour. Providers shall not round up to the nearest unit, and partial units shall not be reimbursed. Time may be accumulated in quarter-hour	Corrected unit values for MHSS, adjusted service limits to retain previous unit values.	The document was originally drafted using one hour unit values with the limitations expressed in one hour values. The unit value was not changed as part of this regulation package.

	increments over the course of one week (Sunday to Saturday) to reach a billable unit. The provider shall clearly document details of the services provided during the entire amount of time billed.		
12VAC30-50-226	Emergency: 15. Mental health skill-building services, which may continue for up to six consecutive months, must be reviewed and renewed at the end of the period of authorization by an LMHP who must document the continued need for the services. Proposed : Service-specific provider intakes shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service.	Changed MHSS to no longer require a service specific provider intake every six months as seen in the proposed regulatory stage. That function was replaced with a "service review" by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP to ensure the individual continues to meet medical necessity criteria.	This change would have a budget impact so it was revised to conform to similar requirements in the CMHRS benefit.
12VAC30-60-143	N/A	Clarified the timeliness requirements in the crisis intervention and crisis stabilization service authorization process to include the response time requirements of the DMAS contractor.	Since stakeholder comment indicated a concern about delaying services because of the service authorization requirement, DMAS wanted to share the timeliness requirement for the BHSA or other contractors administering the crisis services.
12VAC30-60-143	19. If mental health skill-building services are provided in a group home (Level A or B) or assisted living facility, effective July 1, 2014, there shall be a yearly limit of up to 4160 units per fiscal year and a weekly limit of up to 80 units per week, with at least half of each week's services provided outside of the group home or assisted living facility. There shall be a daily limit of a maximum of	Replaced the incorrect MHSS listing of 15 minute unit values and their respective maximum allowances with maximum limitations that match the MHSS unit values defined in 12VAC30-50-226.	This statement was using 15 minute unit values in the proposed text.

	20 units. Prior to July 1, 2014, the previous limits shall apply. The ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.		
12VAC30-60-143	3. The LMHP, LMHP-supervisee or LMHP-resident shall complete, sign, and date the ISP within 30 days of the admission to this service. The ISP shall include documentation of how many days per week and how many hours per week are required to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. The ISP shall indicate the dated signature of the LMHP, LMHP-supervisee or LMHP-resident and the individual.	Changed the MHSS provider requirements for developing the ISP to allow an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E to develop the ISP.	This requirement was mistakenly limiting ISP development to only the LMHP, LMHP-supervisee or LMHP-resident staff. It was amended to align with other adult oriented provider requirements.
12VAC30-60-143	b. Documentation of this review shall be added to the individual's medical record no later than the last day of the month in which this review is conducted, as evidenced by the dated signatures of the LMHP, LMHP-supervisee, LMHP-resident, QMHP-A, QMHP-C or QMHP-E and the individual.	Adjusted the MHSS documentation requirement for the ISP review to match the ISP review definition by requiring the review ”be documented in the individual's medical record no later than 15 calendar days from the date of the review”	Addressed an inconsistent statement with different timelines as identified in a stakeholder comment.
12VAC30-60-143	Documentation requirements were established related to previous psychiatric treatment and previous psychiatric medications.	Discharge summaries from prior providers are permitted to show prior psychiatric treatment. Discharge summaries obtained from prior prescribing providers are permitted to show prior	Discharge summary documentation frequently contains the needed elements; this change permits providers to use

		psychiatric medications. Prior psychiatric medications can also be documented through prescription lists or medical records from current or previous prescribing providers.	discharge documentation to meet requirements. In addition, the requirements are strengthened to ensure that prescription information is obtained from current or prior prescribers.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate. Please distinguish between comments received on Town Hall versus those made in a public hearing or submitted directly to the agency or board.

	Commenter	Comment Summary	DMAS Response
1.	Assn. for Community Based Service Providers	Opposed to 15-minute unit.	The billing unit will not change. This was an oversight in the regulation package by DMAS.
2.	MPNN CSB	Commenter is not sure if DMAS intended to prevent QMHP-E and QMHP-A from completing the ISP for MHSS.	The regulations will be edited to align with current allowances for CMHR services. The revised text will be as follows: An individual service plan (ISP) shall be fully completed, signed, and dated by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-A, QMHP-C, or a QMHP-E and the individual and individual's parent/guardian within 30 days of initiation of services. The ISP shall meet all of the requirements as defined in 12VAC30-50-226.
3.	Fellowship	• It will be difficult and costly	• Refer to response #2

	Health Resources	to hire additional LMHP staff to complete ISPs. The changes have made the service less intensive, but the ISP completion requirements are more intensive. • Opposed to requirement for authorization for Crisis Stabilization: a large amount of paperwork, delay in services. If services are provided prior to authorization, are providers guaranteed payment? • Will claims be denied or retracted for services provided above the days/hours per week set forth in the ISP? • Support the decision not to pursue a change in the unit. • Support changes to include Non-Residential Crisis Stabilization. • Changes have limited access to MHSS services. A system of care needs to be developed and implemented instead of changes to the current system.	• Crisis Services will require authorization to receive reimbursement. The time frames required for submitting the authorization request have been specified. Authorization allows better quality management and opportunities for care coordination • All services must be defined in the ISP or they will be subject to retraction. This is consistent with similar services such as Intensive In-Home. The ISP is an evolving document and should be updated to reflect the changing needs of the individual. • Refer to response #1 • The Medical Necessity criteria will be amended to include non-residential crisis stabilization. • Access to MHSS has remained very stable since 2014 with an average of 10,800 persons receiving the service. The number of individuals served has decreased since the implementation of the new medical necessity criteria. During 2014 an average of 683 persons, or six percent of the monthly

			members, did not pursue an extension of MHSS after December 1, 2013. During the same time period an average of 246 persons per month initiated the service as new recipients of MHSS. Given the initial discussions with stakeholders, DMAS and Magellan analyzed the potential increases in acute and inpatient psychiatric admissions for individuals whose services were discontinued after December 1, 2013. A review of data appears to suggest that, in general, the individuals who were authorized for MHSS continually after December 2013 used acute care hospital services more frequently than the individuals who were discharged from MHSS. Conversely, persons discharged from MHSS, generally have experienced less hospitalizations than those who remained approved for the service since December 2013. This is an improvement in reducing inpatient care to those who were discharged from the service, the persons

			who remained active with MHSS did not experience any different admission rates pre and post December, 2013. • DMAS is pursuing changes to the system of care in other initiatives and potential demonstration projects
4.	VA CSB Quality Leadership Committee	• The regulatory language uses the current unit but the Economic Impact analysis includes the 15-minute unit. The 15-minute unit is preferred. • The definition of "review of ISP" is not consistent with the language in 30-60-143(I)(4)(b). The language in the definition should replace the language in 30-60-143(I)(4)(b). • The registration requirement for Crisis Stabilization and Crisis Intervention should continue, and authorization should not be required for these services. • A new service-specific provider intake (SSPI) should not be required every 6 months for individuals in MHSS. Instead, an LMHP should review the SSPI every 6 months. • QMHPs should be permitted to complete and sign ISPs for MHSS (possibly with LMHP review). • Clearer language is needed regarding the quarterly review of the ISP for MHSS. It can be interpreted that the ISP	• Refer to response #1. • Refer to response #2 • Crisis Services will require authorization to receive reimbursement. The time frames required for submitting the authorization request have been specified. Authorization allows better quality management and opportunities for care coordination by providing information about the persons who need crisis services. • Ongoing assessment and an evidence based assessment process are required to measure treatment progress and assess the service need. Currently the need for continued care is demonstrated by the review of the ISP and the member's needs. The proposed change further reinforces what has been a point that required clarification

		must be updated every three months. • If the unit is changed to 15 minutes, it would not be possible to complete an assessment in this time, and the assessment should be reimbursed as four 15-minute units.	based on the emergency regulations. • Refer to response #2 • ISP's should be updated as needed based on the ever changing needs of the member. The quarterly review is required as defined by DBHDS licensure regulations. • A fifteen minute unit value was not applied to the MHSS service or MHSS assessment.
5.	Individual	Not allowing QMHPs to complete ISPs will require agencies to restructure programs and create additional positions while reducing the clinical work performed by LMHPs. This change creates an increased likelihood of unethical behaviors in order to meet the new standards.	Refer to response #2. Un-ethical clinical practices will be reported to DHP when violations of licensing requirements are observed.
6.	Individual	Not allowing QMHPs to complete ISPs will be costly and will require agencies to make cuts in other areas. In addition, LMHPs do not have as much contact with clients and their ISPs may not be as accurate or detailed.	Refer to response #2.
7.	CIBH	Requiring authorization for Crisis Intervention and Crisis Stabilization is not in the best interests of the individual being served. Authorization creates a barrier to immediate access to a less restrictive level of care that prevents hospitalization.	Refer to response #3
8.	Individual	The SSPI for ICT "cannot be completed by [an] LMHP-RP as the changes in January 2015 do	ICT is a direct treatment service and is not defined as targeted case

		not apply to case management." "What are the purposes for 18VAC125-20-65 and 18VAC140-20-50 generally in reference to LMHP" "…18VAC125-20-10, program for clinical psychologists seemly contradicts and pre-empts the paragraph below 18 VAC140-20-10 … because again 18VAC125-20-10 is too broad definitions and does not reference anything such as other parts of Virginia Administrative Code…"	management (TCM). TCM is not included in ICT. Care coordination is included as part of the ICT service. The references to counseling and social work board regulations is included to reinforce the license requirements of those individuals licensed by those boards and recognized by DMAS as eligible providers of CMHRS.
9.	Individual	Supports addition of Non-Residential Crisis Stabilization as a higher level of care in the consideration of MHSS eligibility criteria.	Refer to response #3
10.	Individual	There is a shortage of LMHPs and it will be difficult to hire LMHPs to complete ISPs. For license eligible residents, "these hours do not count toward licensure and therefore it would decrease or eliminate those individuals from applying for such positons."	Refer to response #2
11.	Individual	"Something missing?" "QMHPs are also not permitted to conduct the service specific provider intake QMHPs are not permitted to render Crisis Intervention services. perfect job Qualifications: Completion of a Master's Degree in social work, sociology, psychology, or licensure track related human service field and some clinical experience, preferably working in a day treatment or similar program for serious emotionally disturbed children. A valid Virginia Driver's License is required for employment. Must	This comment is not clear.

		meet the criteria of a Licensed or Licensed Eligible Mental Health Professional per the Virginia Department of Medical Assistance Services (DMAS) standards by being registered as a supervisee with the Virginia Department of Health Profession"	
12.	Individual	"Please make sure that 18VAC140-20-10 and 18VAC125-20-10 are [u]sed in the proper context for LMHP-resident in psychology."	These regulations are written by the Department of Health Professions, a different state agency.
13.	Individual	Comment submitted via email. Commenter does not support change in criteria as the old criteria prevented hospitalization.	Given the initial discussions with stakeholders, DMAS and Magellan analyzed the potential increases in acute and inpatient psychiatric admissions for individuals whose services were discontinued after December 1, 2013. A review of data appears to suggest that, in general, the individuals who were authorized for MHSS continually after December 2013 used acute care hospital services more frequently than the individuals who were discharged from MHSS. Conversely, persons discharged from MHSS, generally have experienced less hospitalizations than those who remained approved for the service since December 2013. This is an improvement in reducing inpatient care to those who were

			discharged from the service, the persons who remained active with MHSS did not experience any different admission rates pre and post December, 2013.
14.	Henrico Area Mental Health and Developmental Services	Comments submitted via email. • Commenter supports a change to a 15-minute unit. • Clarification is needed regarding the time frame for review of the ISP and if the ISP review is the same as the quarterly review. The regulations should have consistent language that the ISP should be documented no later than 15 days after the review. • Requiring authorization for crisis stabilization and crisis intervention is not in the best interests of the individual needing services; the registration requirement should continue instead. • A new SSPI should not be required after 6 months; instead, the initial intake should be reviewed by an LMHP after 6 months. • QMHPs should be able to complete and sign both initial and annual ISPs. ISP updates should only be required if the needs of the individual change. • Clarify the difference between reviewing the ISP and updating the ISP.	• Majority of comments did not support the change to a 15 minute billing unit • ISP's should be updated as needed based on the ever changing needs of the member. The quarterly review is required as defined by DBHDS licensure regulations. • Refer to response #2. • Refer to response #4. • QMHP's are not licensed to assess or direct treatment so they are not allowed to develop a behavioral health services treatment plan. • Reviewing an ISP is required minimally once every three months as specified by the Department of Behavioral Health and Developmental Services. The goals of the ISP review are to assess progress and evaluate the individual's service needs and wishes and decide whether or not to revise the ISP. The act of revising the ISP

		• The SSPI cannot be completed in 15 minutes, and should be reimbursed at a rate equal to one hour of service.	is the process between the service provider and individual receiving services to initiate changes to the treatment goals and objectives in the MHSS ISP. • Refer to response # 3
15.	Virginia Assn. of Community-Based Providers	• If only LMHP-level staff can complete ISPs, additional staff will need to be hired, and there is already a shortage of individuals with these credentials. This type of work is paperwork and does not meet the requirement for hours toward licensure. This change would make this service differ from others. This approach seems contrary to current trends and would require ISPs to be written by staff who have very little contact with the client. This change will reduce access to services. • Requiring authorization for Crisis Intervention and Crisis Stabilization would delay services during a critical time, which could lead individuals to seek more expensive and intrusive levels of care. It is not clear if providers would be reimbursed for services during this delay if services were then denied. • Creating a new SSPI after 6 months would be an unnecessary burden and distraction from care; the intake should just be reviewed. • It is not clear if providers will be reimbursed for services	• Refer to response #2 • Refer to response #3 • Refer to response #4 • All services must be defined in the ISP or they will be subject to retraction. This is consistent with similar services such as Intensive In Home. The ISP is an evolving document based on the needs of the individual and as it is updated the individual signs to demonstrate agreement with the change, the service provider should ensure a person centered process is used during treatment planning and development of the ISP. • Refer to response #1 • Refer to response #3

		that exceed the levels contained in the ISP; this is not person-centered. • The commenter supports the decision not to implement the 15-minute unit. The commenter supports the addition of Non-Residential Crisis Stabilization.	
16.	Individuals	• Removal of the requirement for hospitalization "goes against the ADA of least-restrictive environment and denies services to those who have mental health disabilities." • "WRT persons un[d]er the age of 21 years who live with parents or guardians. With whom one lives and one's chronological age are NOT factors determining the need of MHSS. Additionally, most care givers of persons with chronic, life-long mental health disorders need the support of the MHSS teams to reinforce the skills they teach their dependent. • "Lastly, the idea that these services can be provided by the local community service boards is laughable! The CSBs are overworked and understaffed already, having waiting times of up to a month in many locales. So, one might hypothesize that saving money from individual corporations and giving it to the CSBs would allow the CSBs to accommodate the increased need. HA! Anyone who has studied government understands that, when a government entity is given an	• Refer to response #3 related to medical necessity. • An Individual's existing natural support system will be considered further as it relates to the medical necessity criteria and service definition of MHSS.MHSS can be provided by CSB's or private providers. • The Program Integrity Division investigates companies that fail to provide proper services or that misuse funds. If individuals have knowledge about companies that are acting improperly, they can report them to DMAS.

		increase in budget for a program, the first thing that happens is a new level of middle management is created, and few of the dollars fund the issues for which the program was created. In a private corporation, the business is in business - they have to make a profit to stay in business, so they manage their time and funds more effectively. • If there are problems with private companies failing to provide proper services or misusing funds, take them down! Don't throw out all of the companies because of a few bad ones. Seriously."	
17.	Chesapeake Integrated Behavioral Healthcare	• Completing a SSPI every 6 months is not practical, creates an additional burden, and yields very little information that could not be gathered through review and consultation. • QMHPs should be able to complete and sign the ISP with review by an LMHP. The commenter supports the 15-minute unit.	• Refer to response #4. • Refer to response #2. • Refer to response #1.
18.	EHS Support Services (6 commenters)	• Requiring LMHPs is contrary to current trends in the mental health field and requires additional staff at high salaries which causes budget concerns. Will also create delays in documentation and services. There is a shortage of LMHPs and time spent writing ISPs will not be counted to licensure. • Requiring authorization for crisis services will delay	• Refer to response #2. • Refer to response #3. • Refer to response #1. • Refer to response #3. • Refer to response #2. • Refer to response #2. • Refer to response #3. • Refer to response #2. • There is no budget authority to increase the reimbursement rate for MHSS.

		services and during the delay the individual may require a more expensive and higher level of care. • Supports removing the 15-minute unit. • Supports Non-Residential Crisis Stabilization Services as an eligibility criterion for follow-up MHSS. • QMHPs know the clients best and should continue to write ISPs. • "I have a problem with the proposed changes to my field. I am aware that there are not many LMHP's to choose from and this would effect my ability to work. With this change, my company and companies like ours, may not be able to stay in business and our client's will still need the assistance. Now there could be more mental health citizens in need of care." • Does not support the ISP limit on the days/hours of service provided. The need for service fluctuates. • A higher "documentation to clinical service" ratio creates burnout, job dissatisfaction, fewer appointments, and disengagement among clients. Increase funding for MHSS to help individuals stabilize their lives.	
19.	ChildSavers	Requiring authorization of Crisis Intervention is not client centered and does not support the service requirement that the provider be available 24/7 to provide crisis services. The current requirement for service registration is preferable.	Refer to response #3.

20.	Individual	Supports allowing non-residential crisis stabilization to be considered as a higher level of care for MHSS eligibility.	Refer to response #3.
21.	Individual	• Requiring an LMHP to complete, sign, and date an ISP will limit mental health services in rural areas. LMHP-types will not be able to count ISPs toward residency requirements and requires LMHPS to do paperwork rather than clinical work. MHSS is only service that requires this. LMHPs cost more and this could result in efficiency measures that are not person centered. • Authorization should not be required for Crisis Intervention or Crisis Stabilization. The delay in the authorization process could harm clients and result in the need for more costly services. • A service specific provider intake should not be required every six months. A review of the original intake should be sufficient. • There should be flexibility in the number of days/hours of service per week. • Supports the removal of the 15-minute unit. Supports allowing non-residential crisis stabilization to be considered as a higher level of care for MHSS eligibility.	• Refer to response #2. • Refer to response #3. • Refer to response #4. • Refer to response #3. • Refer to response #1. • Refer to response #3.
22.	True Life Destinations – 7 commenters	• Psychological problems may contribute to medical problems. Think about the lack of community resources and cost savings efforts. The changes will hinder private sector staff and owners and	• Refer to response #3. • Refer to response #3. • Refer to response #1 and #3. • Ensuring that Virginians receive

		affect clients. • "Changes should not be made that will jeopardize the mental health needs of clients. Cutting any pay to those that provide services will cause many qualified professionals to seek other employment. The only positive change would be eliminating the hospitalization requirement to receive services." • "Decreasing the pay to those that provide Mental health skill building services will deter qualified professionals. Changes should not be made that might jeopardize the quality of services offered to clients/potential clients. What needs to be discussed is how to incorporate more programs and funding so that clients get quality care and the help they need before they harm themselves, others, or are hospitalized." • "Without TLD, I wouldn't be at my highest functioning level. My worker helps me in the areas that I struggle with." • "I want to voice concerns primarily in reference to the hospitalization requirement. This impacts the access to those in need of services for a variety of reasons. Mental health challenges, often go unaddressed and increase harmful risk of family instability, elevated rates of homelessness, and joblessness… Mental health problems and lack of care for those problems create numerous factors to consider	high quality mental health care that improves their functioning is an important goal of DMAS. • Refer to response #3. • Refer to response #1. • Refer to response #1.

		such as substance abuse disorders and problematic alcohol use. For some the stigma of being hospitalized is embarrassing. Barriers to care can also breed increased levels of violent behaviors related to mental health. We need to create easier access for people suffering from Mental Health disorders." • Does not support the 15-minute unit/rate change. The cost paid for mental health services should not be lowered because it may cause some providers to no longer offer needed services.	
23.	Individual	The private sector company the commenter uses is resourceful and very helpful in providing me the necessary tools I need to live a more independent life.	Ensuring that Virginians receive high quality mental health care that improves their functioning is an important goal of DMAS.
24.	Martinsville EHS	Does not support authorization for crisis services. Authorization can take two to five days, which delays treatment and could allow symptoms to worsen, requiring hospitalization. It is not clear if services provided pending authorization would be reimbursed.	Refer to response #3.
25.	EHS (2 commenters)	• If LMHPs are required to complete ISPs, there will be additional costs, which may decrease care in other areas. Work on ISPs does not count toward licensure. LMHPs will have difficulty creating accurate ISPs because they are with the individual for a limited amount of time. • Requiring an authorization for Crisis Stabilization could delay care and could cause the	• Refer to response #2. • Refer to response #3. • Refer to response #3.

		need for hospitalization. Supports the addition of Non-Residential Crisis Stabilization services as a higher level of care in the consideration of MHSS eligibility criteria.	
26.	Individual	[Some of text submitted is identical to that submitted by EHS on 10/19/15.] • Does not support requirement that LMHPs create ISPs. Does not support authorization for crisis services.	• Refer to response #2. • Refer to response #3.
27.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. This change could reduce the number of psychiatric beds available in Virginia.	• Refer to response #2. • Refer to response #3. • Refer to response #13.
28.	Individual	• The changes requiring adults to have a history of hospitalization has made it "nearly impossible to provide proactive assistance to individuals." • "I used to work for an agency that committed millions of dollars worth of fraud. I did everything I was supposed to when I discovered fraud within the company… and for that I am repaid by now worrying that my n[e]w business will be greatly affected by rate cuts, qualification changes, and more upheaval." • Licensure regulations should be the same for all providers. • Community Service Boards cannot provide all needed services. Also supports the VACPB	• Refer to response #3. • The Program Integrity Division investigates companies that fail to provide proper services or that misuse funds. If individuals have knowledge about companies that are acting improperly, they can report them to DMAS. • The Department of Behavioral Health and Developmental Services sets licensure regulations. The code of Virginia allows a different set of professional license requirements for publicly funded entities to provide mandated services.

		comments (submitted on 10/3/15).	• CSBs and private providers can offer MHSS, individuals have the right to choose any available MHSS provider within their service area.
29.	Hampton-NN CSB	• The SSPI does not need to be repeated after 6 months. Treating chronic conditions and it is better to assess over a longer timeframe. The SSPI was not designed to assess progress over time. • Requiring the LMHP to complete the ISP is not a best practice and could result in a delay of service initiation, as the QMHP will not be able to develop a therapeutic rapport with the client until the ISP is completed. Also, requiring LMHPs to complete ISPs would increase the staff costs for this service.	• Refer to response #4. • Refer to response #2.
30.	Individual	Does not support requirement that LMHPs create ISPs.	Refer to response #2.
31.	Individual	• Does not support requirement that LMHPs create ISPs. Does not support authorization for crisis services.	• Refer to response #2. • Refer to response #3.
32.	St. Joseph's Villa	• Suggest removing experience with intellectual disability or geriatric services from the clinical experience definition as this conflicts with DBHDS documents (QMHP/QMRP/QPPMH Definitions and Human Services and Related Fields Approved Degrees/Experience) • Recommend adding frequency required to the "Review of ISP" definition on page 3. Additionally, the 15	• DBHDS list the requirements for a QMHP, QMRP, and QPPMH in the guidance document: "Definitions and Human Services and Related Fields Approved Degrees/Experience". And also in 12VAC35-105-20. DMAS will amend regulatory language in 12VAC30-50-226 to

		calendar days allowed to complete the report conflicts with information on page 19, 4b which allows until the last day of the month in which the report is due. • Page 11 -- We have been informed by Magellan that service coordination activities are billable as long as they are described in the ISP. Page 11 indicates that only face to face services are billable. Please clarify. • Page 19, #3 does not include QMHP's as qualified to complete ISP's. This conflicts with page 14, #7 which allows QMHP's and QMHP-E's to complete the ISP. • Page 21, #16 allows supervision of QMHP-E's to be provided by a LMHP-supervisee, LMHP-resident, and QMHP. The current Community Mental Health Rehabilitative Services Manual, chapter 2, page 12 requires that supervision be provided by a LMHP. I agree that a LMHP-supervisee and LMHP-resident should be able to provide supervision for a QMHP-E. Is the inclusion of a QMHP an error? Crisis Stabilization – page 7 should indicate that registration is required instead of authorization.	remove the terms "or intellectual disability" to align the requirements to the current DBHDS regulation as specified in 12VAC35-105-20. • The ISP review documentation requirements will be assessed for consistency and will be clarified for MHSS and potentially for other CMHRS impacts. • Care Coordination or Service Coordination activities are a requirement for all CMHRS service providers as part of the service being rendered. Reimbursement for MHSS is limited to the duration of Face to Face service delivery encounters. • Refer to response #2. • The supervision of QMHP-E's must be provided by a fully licensed LMHP. An LMHP-R, LMHP-S and LMHP-RP's may not yet provide clinical supervision according to DHP regulations. • Refer to response #3.
33.	Individual	"I have followed regulation proposals for Mental Health legislation in Virginia and I am noticing an alarming trend. There exists countless instances	• Post payment review audits are coordinated to ensure services are provided in accordance with

		in which reactionary proposals continuously spew out with careless impact analysis for the sole reason to immediately mitigate the financial damages of a broken system. This ideology will not work. If the primary reason for reactionary regulation proposals is ultimately for financial recapture (as I personally believe it is), then I propose that Virginia end this archaic system of thinking and adopt a proactive approach by implementing a more efficient auditing process with stricter consequences for the agencies and individuals who abuse the system." • Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	regulations. Individual providers who "abuse the system" are referred to the Medicaid Fraud Control Unit at the Virginia Office of Attorney General • Refer to response #2. • Refer to response #3. • Refer to response #3.
34.	Individual	• Does not support requirement that LMHPs create ISPs. Does not support authorization for crisis services.	• Refer to response #2. • Refer to response #3.
35.	Individual	Does not support requirement that LMHPs create ISPs	• Refer to response #2.
36.	Individual	• Does not support requirement that LMHPs create ISPs. Does not support authorization for crisis services.	• Refer to response #2. • Refer to response #3.
37.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. Outpatient crisis stabilization	• Refer to response #2. • Refer to response #3. • Since all inpatient services require authorization it is consistent to require

		services should be treated the same as inpatient crisis stabilization.	authorization for crisis services too. This change allows enhanced care coordination to assess and if necessary, help to manage the high intensity needs of the individuals who require crisis services.
38.	Individual	Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	Refer to response #3.
39.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	• Refer to response #2. • Refer to response #3. • Refer to response #3.
40.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. • Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS. Commenter feels that if individuals in charge of making regulatory changes worked as an MHSS team member for a week, they would better understand what is needed and what is not needed.	• Refer to response #2. • Refer to response #3. • Refer to response #3. • DMAS worked closely with providers and stakeholders throughout the process of designing the MHSS regulations.
41.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	• Refer to response #2. • Refer to response #3. • Refer to response #3.

42.	Individual	Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	Refer to response #3.
43.	Individual	Does not support requirement that LMHPs create ISPs.	Refer to response #2.
44.	Individual	Does not support authorization for crisis services.	Refer to response #3.
45.	Individual	Does not support requirement that LMHPs create ISPs.	Refer to response #2.
46.	Individual	• Does not support requirement that LMHPs create ISPs. Does not support authorization for crisis services.	• Refer to response #2. • Refer to response #3.
47.	Individual	• Does not support the ISP limit on the days/hours of service provided. The need for service fluctuates. Does not support authorization for crisis services.	• Refer to response #3. • Refer to response #3.
48.	Individual	Supports removing the 15-minute unit.	Refer to response #1.
49.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. • Does not support the ISP limit on the days/hours of service provided. The need for service fluctuates. Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	• Refer to response #2. • Refer to response #3. • Refer to response #3. • Refer to response #3.
50.	Individual	All providers are not held to the same standard. Larger providers are audited once a year while smaller providers are not audited. DMAS should enforce regulations that are already in place.	Post payment review audits are coordinated to ensure services are provided in accordance with regulations. Magellan provides enhanced quality of care reviews and increases the capacity for more efficient management of fraud, waste and abuse. Both large and small providers

			receive quality reviews and receive a post payment record review or "audit"
51.	Individual	• Does not support requirement that LMHPs create ISPs. Does not support authorization for crisis services.	• Refer to response #2. • Refer to response #3.
52.	Family Insight	• Does not support requirement that LMHPs create ISPs. • DMAS should enforce regulations that are already in place. • The reimbursement rates paid to LMHPs should increase.	• Refer to response #2. • Refer to response #28, #33 and response #50. • There is no budget authority to increase the reimbursement rate for MHSS.
53.	East Mental Health	• No content included.	• N/A
54.	Support Systems	• Commenter has discussed need for preventive mental health care with DMAS and the Secretary of Health. • Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. • Does not support the ISP limit on the days/hours of service provided. The need for service fluctuates. • Supports removing the 15-minute unit. • Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	• DMAS appreciates the involvement and participation by stakeholders in the process of discussing and developing these regulatory changes. • Refer to response #2. • Refer to response #3. • Refer to response #3. • Refer to response #1. • Refer to response #3.
55.	ResCare/Creative Family Solutions (4 commenters)	• Does not support requirement that LMHPs create ISPs. • Does not support the ISP limit on the days/hours of service provided. The need for service fluctuates. • Does not support authorization for crisis	• Refer to response #2. • Refer to response #3. • Refer to response #3.

		services.	
56.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support the ISP limit on the days/hours of service provided. The need for service fluctuates. • Does not support authorization for crisis services.	• Refer to response #2. • Refer to response #3. • Refer to response #3.
57.	Individual	• Does not support requirement that LMHPs create ISPs. • Does not support authorization for crisis services. • Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS.	• Refer to response #2. • Refer to response #3. • Refer to response #3.
58.	Mainstream Mental Health Services	• Does not support requirement that LMHPs create ISPs. • Does not support the ISP limit on the days/hours of service provided. The need for service fluctuates. • Supports removing the 15-minute unit. • Supports adding non-residential crisis stabilization to the eligibility criteria for MHSS. • Commenter challenges the validity of a history of hospitalization, PACT, ICT, ECO because a history of treatment is dependent on many factors including financial and personal resources, level of education, support network, cultural beliefs, and personal experience.	• Refer to response #2. • Refer to response #3. • Refer to response #1. • Refer to response #3. • MHSS medical necessity criteria were revised to ensure that individuals who require ongoing services and supports to manage a serious mental illness are served in the least restrictive environment. Each request for service is reviewed to determine if the individual's needs meet the medical necessity criteria and to assess individualized service needs and ensure the correct level of care is provided to the individual based on

			their clinical need for services.
59.	Family Preservation Services	• The regulations will disproportionately affect rural communities where a full service continuum often does not exist. MHSS serves an important role in rural areas where there are many service gaps. Commenter is concerned that changes in eligibility will have an adverse impact in rural areas where there are few options for care. Commenter is hopeful that DMAS and DBHDS continue to develop services that meet gaps in care. • Commenter recommends 12-month service-specific provider reassessment rather than 6-month reassessment because changes take longer than 6 months.	• DMAS, DBHDS and Magellan are all actively pursuing initiatives that will enhance the services available throughout Virginia. Each request for service is reviewed to determine if the individual's needs meet the medical necessity criteria and to assess individualized service needs and ensure the correct level of care is provided to the individual based on their clinical need for services. • Refer to response #4.

All changes made in this regulatory action

Please list all changes that are being proposed and the consequences of the proposed changes. Describe new provisions and/or all changes to existing sections. Explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12 VAC 30-50-226		Mental health support services are established and defined.	In order to qualify for this service, an individual must have a recent qualifying Axis I DSM diagnosis, a prior history of psychiatric hospitalization, etc., and have a prescription for required psychiatric medications.
12VAC 30-50-226		Behavioral Health Services Administrator defined.	Added definition of Behavioral Health Services Administrator (BHSA) to clarify the authority to oversee a provider network for the provision of Medicaid-covered behavioral

			health services.
12 VAC 30-60-143		Utilization control requirements for mental health support services.	Providers must document the required diagnosis; this service cannot be rendered simultaneously with other specified State Plan and waiver services; this service cannot duplicate other services.