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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12VAC30-10-540, 12VAC30-30-10, 12VAC30-50-130, 12VAC30-50-226, 12VAC30-50-9999, 12VAC30-60-5, 12VAC30-60-50, 12VAC30-60-61, 12VAC30-130-850, 12VAC30-130-860, 12VAC30-130-870, 12VAC30-130-880, 12VAC30-130-890; 12VAC30-130-3000, 12VAC30-130-3020
Regulation title(s)	Residential Treatment Services Emergency Regulations: Amount, Duration and Scope of Medical and Remedial Services; and Standards Established and Methods Used to Assure High Quality of Care
Action title	Psychiatric Residential Treatment Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications
Date this document prepared	January 8, 2018

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 (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

The DMAS psychiatric residential treatment service was implemented in 2001 and the associated regulations have not been updated since then. The existing regulations are not adequate to ensure successful treatment outcomes are attained for the individuals who receive high cost high intensity residential treatment services. Since moving behavioral health services to Magellan (the DMAS Behavioral Health Service Administrator, or BHSA) there has been enhanced supervision of these

services. The enhanced supervision has led to an increased awareness of some safety challenges and administrative challenges in this high level of care. The proposed revisions will serve to better clarify policy interpretations that revise program standards to allow for more evidence based service delivery, allow DMAS to implement more effective utilization management in collaboration with the BHSA, enhance individualized coordination of care, implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, and support DMAS audit practices. The changes will move toward a service model that will reduce lengths of stay and facilitate an evidence based treatment approach to better support the individual's discharge into their home environment. These changes also align DMAS in meeting the requirements set forth by the Centers for Medicare and Medicaid Services (CMS) in 42CFR 441 Subpart D and 42CFR 441.453.

The proposed stage action incorporates changes made at the emergency stage, including changes to the following areas: (i) provider qualifications including acceptable licensing standards; (ii) pre-admission assessment requirements, (iii) program requirements, (iv) new discharge planning and care coordination requirements and; (iv) language enhancements for utilization review requirements to clarify program requirements, ensure adequate documentation of service delivery, and help providers avoid payment retractions. These changes are part of a review of the services to ensure that they are effectively delivered and utilized for individuals who meet the medical necessity criteria. For each individual seeking residential treatment their treatment needs are assessed with enhanced requirements by the current Independent Certification Teams who must coordinate clinical assessment information and assess local resources for each person requesting residential care to determine an appropriate level of care. The certification teams are also better able to coordinate referrals for care to determine, in accordance with DOJ requirements, whether or not the individual seeking services can be safely served using community based services in the least restrictive setting. Independent Team Certifications are conducted prior to the onset of specified services, as required by CMS guidelines, by the DMAS Behavioral Health Services Administrator.

The proposal includes changes to program requirements that ensure effective levels of care coordination and discharge planning occurs for each individual during their residential stay by enhancing program rules and utilization management principles that facilitate effective discharge planning, family engagement and establish community-based services prior to the individual's discharge from residential care. The proposal requires enhanced care coordination to provide the necessary, objective evaluations of treatment progress and to facilitate evidence based practices during the treatment to reduce the length of stay by ensuring that medical necessity indicates the correct level of care and that appropriate and effective care is delivered in a person centered manner. The proposal requires that service providers and local systems will use standardized preadmission and discharge processes to ensure effective services are delivered.

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.

BHA = Behavioral Health Authority
BHSA = Behavioral Health Services Administrator
CMS = Centers for Medicare and Medicaid Services
CSA = Comprehensive Services Act
CSB = Community Services Board
DBHDS = Department of Behavioral Health and Developmental Services
DMAS = Department of Medical Assistance Services
DOJ = Department of Justice
EPSDT = Early Periodic Screening, Diagnosis, and Treatment
FAPT = Family Assessment and Planning Team
FFP = Federal Financial Participation
FFS = Fee for Service
ICF/ID = Intermediate Care Facility for the Intellectually Disabled
ICF/MR = Intermediate Care Facility for the Mentally Retarded
IMD = Institution for Mental Disease
MCO = Managed Care Organization
MDT = Multi-Disciplinary Treatment Team

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.

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 agency is proposing this regulatory action to comply with Chapter 665 Item 301.PP of the 2015 *Acts of Assembly* which states:

"The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."

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.

This regulatory action is essential to protect the health, safety, or welfare of Medicaid-covered individuals who require behavioral health services and their families to ensure that: they are well informed about their behavioral health condition and service options prior to receiving these services; the services are medically necessary; and the services are rendered by providers who use evidence based treatment approaches.

When residential treatment services were implemented by DMAS, individuals did not have access to standardized methods of effective care coordination upon entry into residential treatment due to placement processes at the time and DMAS reimbursement limitations. This resulted in a fragmented coordination approach for these individuals who were at risk for high levels of care and remained at risk of repeated placements at this level of care. Also, at the time of the Appropriations Act mandate, the process in place for Medicaid enrolled children placed in Residential settings yielded an average stay of 260 days – with high readmissions rates.

While residential treatment is not a service that should be approved with great frequency for a large number of individuals it is a service that should be accessible to the families and individuals who require that level of care. The service model had significant operational layers to be navigated to access residential services. The processes involved coordination of care by local FAPT teams who have, over time, demonstrated some influence on determining an individual's eligibility for FAPT funded services. The local influence on the programs administration caused limitations on individualized freedom of provider choice and inconsistent authorization of funding for persons deemed to need psychiatric care out of the home setting. This local administration of the primary referral source for residential treatment was outside the purview of DMAS and this situation produced outcomes that are inadequate to meet CMS requirements on ensuring the individual freedom of choice of providers.

Also of significant importance, the State rules on FAPT composition were not consistent with the federal Medicaid requirement for certifying a child for a Medicaid-funded residential treatment placement. Changes to the program were necessary to address concerns that arose from the reliance upon the FAPT to fulfill the role as the federally mandated independent team to certify residential treatment.

The residential treatment model requires an enhanced care coordination model to support the individuals who receive this level of service to ensure an effective return to the family or caregiver home environment with follow up services to facilitate ongoing treatment progress in the least restrictive environment. The added coordination is required to navigate a very complex service environment for the individual as they return to a community setting to establish an effective aftercare environment that involves service providers who may be contracted with a variety of entities such as DMAS contracted MCO's, enrolled providers, the local FAPT team, local school divisions and the local CSB. This regulation allows DMAS to implement a contracted care coordination team to focus on attaining specific clinical outcomes for all residential care episodes and to provide a single liaison that will ensure coordination of care in a complex service

environment for individuals upon discharge from residential treatment and prior to the time when they will enroll in an MCO. (During this transition period the individual is very vulnerable to repeated admissions to residential or inpatient care and must be supported in the FFS environment with resources from the local CSB and enrolled service providers, and requires ongoing support and coordination to receive post discharge follow up and transition services.)

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. Residential Treatment services consist of behavioral health interventions and are intended to provide high intensity clinical treatment that should be provided for a short duration. Stakeholders' feedback supported DMAS' observations of lengthy durations of stay for many individuals. Residential treatment services will benefit from clarification of the service definition and eligibility requirements, to ensure that residential treatment does not evolve into a long term level of support instead of the high intensity psychiatric treatment modality that defines this level of care.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

The sections of the State Plan for Medical Assistance that are affected by this action are: Inspection of Care in Intermediate Care Facilities (12VAC30-10-540), Mandatory Coverage: Categorically Needy and other required special groups (12VAC30-30-10), the Amount, Duration, and Scope of Medical and Remedial Services Provided to Categorically/Medically Needy Individuals-EPSDT Services (12 VAC 30-50-130); Applicability of utilization review requirements (12VAC30-60-5), Utilization control: Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD) (12VAC30-60-50) and Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children (12VAC30-60-61). The state-only regulations that are affected by this action are Residential Psychiatric Treatment for Children and Adolescents (plans of care; review of plans of care (12VAC30-130-850 through 130-890).

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.

The primary advantages of these regulations to the Commonwealth and to Medicaid members are that they: (i) better clarify policy interpretations that revise program standards to allow for more evidence based service delivery, (ii) allow DMAS to implement more effective utilization management in collaboration with the BHSA, (iii) enhance individualized coordination of care,

implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, (iv) support DMAS audit practices, and (v) move toward a service model that will reduce lengths of stay and facilitate an evidence based treatment approach to better support the individual's discharge into their home environment.

There are no disadvantages to the Commonwealth or the public as a result of these regulations.

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.

These regulatory changes are not more restrictive than applicable federal requirements.

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 locality will be particularly affected by these regulations, as the changes apply statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

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

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to [insert: staff contact person's name, mailing address, phone number, fax number and email address]. Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including: **a) fund source / fund detail; and** **b) a delineation of one-time versus on-going expenditures**	There are no projected costs to the state.
Projected cost of the new regulations or changes to existing regulations on localities.	There are no projected costs to localities.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	Therapeutic group homes, residential treatment facilities, and community mental health service providers will be affected. IACCT and FAPT teams will also be affected.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	# of therapeutic group homes - 90 # residential treatment facilities – 18 # localities – 128 # of CMHRS providers - 3,545 distinct provider locations. # of IACCT providers – 23 organizations, including CSBs, CSA and private providers. # of FAPT teams – 128
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: **a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and** **b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.**	None.
Beneficial impact the regulation is designed to produce.	The regulations are designed to provide clarity and enhance the quality of care provided.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action.

Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

No other alternatives will meet the General Assembly mandate.

Regulatory flexibility analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

No other alternatives will meet the mandate of the General Assembly.

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, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

Commenter	Comment	Agency response
disAbility Law Center of Virginia	Urge DMAS to include additional language specific to the care coordination	This will be clarified in the RTS Provider manual and trainings with DMAS contractors and providers.

	and discharge planning needs of dually diagnosed youth in PRTFs.	
Individual	Appreciates the focus on family engagement. Family engagement needs to include significant time providing education about the child's diagnoses and challenges and effectives strategies for dealing with those challenges. This can be met through family coaching model. This is all critical for parents and other caregivers to be able to learn new ways of interacting with their child, and to maintain and build on the gains that are made in the residential setting. 1. It is not clear how the identification of the need and approval process for residential services works for children not currently receiving Medicaid coverage. Would such children start with the FAPT process, or do they go straight to the BHSA for the medical coverage and simultaneously to the FAPT team for the educational coverage? 2. For children not currently on Medicaid, does the coverage become retroactive to the first day of the residential admission or to the first day of the next month after the application for Medicaid coverage is filed? 3. For children who were not financially eligible for Medicaid, but who became eligible through the process of admission for residential treatment, how long will the eligibility last? Will it last long enough for in home and community care that is planned as part of the discharge from the residential center? 4. In a few places in the regulations (for example, 12VAC30-60-61 D 15), the parent is **required** to give written consent that this provider has permission to inform the primary care provider of the child's or adolescent's	1. DMAS does not have authority for children who do not have Medicaid eligibility. 2. DMAS has a process for children who become eligible for Medicaid after placement in the residential treatment facility. 3. Children who become eligible for Medicaid due to placement in an institution will retain Medicaid eligibility during placement but will be re-evaluated upon discharge for continued Medicaid eligibility. 4. 12VAC30-60-61 D 15 did not change with this regulatory action.

	receipt of community mental health rehabilitative services. This seems to contradict the principles of giving parents the primary decision-making power and treating them as equal partners (from the Building Bridges Initiative).	
VCOPPA	1. Training has not yet been scheduled for providers to assist them with becoming ready for implementation on July 1, 2017. 2. The definition of "interventions" needs to be clarified and the documentation requirements need to be refined to make sure providers are not penalized for missed interventions. 3. More clarification is needed on what a provider must do to successfully meet requirements for family engagement. There are potential licensing and operational conflicts between state agencies, as well as liability concerns. Integrating families into programmatic structure should be done in ways that don't engender confusion or risk and training is needed. 4. The issue of therapeutic leave needs to be clarified before implementation. 5. The regulations may bind providers to a rigid system that will not allow adequately for individualized treatment, and 6. it is recommended that recommend that the Behavioral Health Services Administrator be granted the authority to review each Service Authorization Request, and review admission and continued stay based on the	1. Magellan held several webinar trainings in the Spring 2017 and posted as recorded webinar on magellanofvirginia.com. DMAS has address and clarified with providers. • May 19, 2017 – Youth Guided Treatment Webinar • May 8, 2017 Family Engagement Training • April 25, 2017 – Regulation Refresher Webinar • Spring 2017 – Refresher Webinar • December 2016 – BBI Overview • Fall 2016 – 4 Regional Trainings 2. Language has been clarified in Fall 2016 based on provider input and defined in the current RTS Provider Manual. 3. These issues are not correctly stated. DBHDS and DMAS clarified this in early January 2017, prior to the public comment period. 4. Therapeutic leave has been clarified in the RTS Provider manual. 5. Regulations were developed by the workgroup consisting of providers to allow more flexible programming to ensure treatment is individualized.

	programming that is being proposed by the provider.	6. The BHSA licensed behavioral health provider reviews SRAs every 30 days based on the child's clinical needs. The BHSA provides care coordination based on the child's needs and readiness for discharge. The programming should be based on the child's needs and family's goals. This is defined in the RTS Provider Manual.
Newport News Behavioral Health Center	The commenter is concerned about the 3 individual sessions per week provided by a clinician: not sure there is therapeutic value to 3 individual sessions per week, and this requirement is contradictory to the goal of providing individualized treatment.	The 2015 workgroup composed of RTS providers suggested this as part of the level of care requirements.
Liberty Point Behavioral Healthcare	1. The prescriptive approach in the regulations does not focus on how to reconcile diverse needs, innovation in the marketplace, and outcomes. There is a focus on compliance instead of efficient patient care. Providers should be given flexibility to achieve results and be accountable to those results. 2. The commenter recommends that the Behavioral Health Services Administrator be granted the authority to review each Service Authorization Request, and review admission and continued stay based on the programming that is being proposed by the provider. 3. Speak with individuals receiving services to determine how they feel about the current academic and treatment structure.	1. Regulations allow for flexible programming and use of evidenced based modalities. IACCT is performing the assessments to determine the member and family needs, strengths and goals and provided to the RTS provider to develop family directed, youth guided and person centered treatment planning. Outcomes are assessed based on the individual's needs. Providers are encouraged to deliver individualized care. 2. See VCOPPA response #6. 3. Comment is unclear. Treatment is person centered and include individual choice in the treatment planning process so their goals are included in the individualized program.
Harbor Point Behavioral Health Center	1. The commenter recommends that the Behavioral Health Services Administrator be granted the authority to review each Service Authorization Request, and review admission and continued stay based on the	1. See VCOPPA response #6. 2. See Liberty Point comment #1-3.

	programming that is being proposed by the provider. 2. Speak with individuals receiving services to determine how they feel about the current academic and treatment structure.	
The Hughes Center	1. The regulations bind providers to a rigid system that does not allow for individualized treatment. 2. The commenter recommends that the Behavioral Health Services Administrator be granted the authority to review each Service Authorization Request, and review admission and continued stay based on the programming that is being proposed by the provider. 3. Speak with individuals receiving services to determine how they feel about the current academic and treatment structure.	See Liberty Point responses.

Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please list separately: (1) all differences between the **pre**-emergency regulation and this proposed regulation; and 2) only changes made since the publication of the emergency regulation.*

Changes in Emergency Regulation:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12VAC30-10-540		Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals under 21, and Mental Hospitals	Terminology change to transition from using the term “the mentally retarded” to using the term “persons with intellectual disabilities”.

12VAC30-50-20		Services provided to the categorically needy without limitation	Clarified that inpatient psychiatric facility services and residential psychiatric treatment services are covered for individuals under age 21.
12VAC30-50-30		Services not provided to the categorically needy	Removed language that stated that inpatient psychiatric facility services were not covered.
12VAC30-50-60		Services provided to all medically needy groups without limitations	Clarified that inpatient psychiatric facility services and residential psychiatric treatment services are covered for individuals under age 21.
12VAC30-50-70		Services or devices not provided to the medically needy	Removed language that stated that inpatient psychiatric facility services were not covered.
12 VAC 30-50-130		EPSDT services provides for inpatient psychiatric services for individuals younger than 21 years of age and sets out the licensing/accreditation requirements that must be met by the defined Inpatient Psychiatric Facilities.	New text includes significantly more detail regarding covered services, incorporations of repealed regulatory text from 12VAC30-130-850-890, EPSDT criteria, independent certification team provider requirements and required activities, admission practices, plan of care requirements, new definitions, changes to service names, elimination of Level A service, enhanced program requirements, care coordination and discharge planning requirements.
12VAC30-60-5		Applicability of utilization review requirements	Deleted the term “unless otherwise specified” to better clarify documentation requirements.
12 VAC 30-60-50		Utilization control: Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Persons with Intellectual Disablity (ICF/ID) and Institutions for Mental Disease (IMD).	Added term “Persons with Intellectual Disability (ICF/ID”, added definition for Institution for Mental Disease, or "IMD" changed the term ICF/MR to ICF/ID where possible and added quality assurance requirements for the pre admission diagnosis and the independent certification team, referenced the reporting requirements for serious incidents and restraints
12VAC30-60-61		Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children.	New text includes service requirements, provider requirements and required activities, incorporations of repealed regulatory text from 12VAC30-130-850-890, EPSDT criteria, changes to terminology to replace ISP with CIPOC, admission and intake requirements, plan of care requirements, new definitions, changes to service names, elimination of Level A service, enhanced program requirements, care coordination and discharge planning requirements. referenced the reporting requirements for serious incidents and restraints

12VAC 30-130-850 through 890		REPEALED	Moved content to other regulatory sections.
12VAC 30-130-3000		Includes language referring to Level A and B group homes.	Updated language to therapeutic group homes and now also includes psychiatric residential treatment facilities.
12VAC 30-130-3020		Requires an independent clinical assessment for Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services for individuals under 21 years old.	Sunsets the independent clinical assessment at the time this emergency regulation is promulgated.

Changes between Emergency Regulation and Proposed Stage:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12 VAC 30-10-540			Language was updated from plural (“are”) to singular (“is”) for clarity.
12 VAC 30-50-20		Inpatient and residential psychiatric services are not specifically listed as covered services.	Inpatient and residential psychiatric services for individuals under the age of 21 are added to the list of covered services.
12 VAC 30-50-30		Inpatient psychiatric facility services for individuals under the age of 21 are incorrectly listed as “not covered.”	This incorrect language was removed.
12 VAC 30-50-60		Inpatient and residential psychiatric services are not specifically listed as covered services.	Inpatient and residential psychiatric services for individuals under the age of 21 are added to the list of covered services.
12 VAC 30-50-70		Inpatient psychiatric facility services for individuals under the age of 21 are incorrectly listed as “not covered.”	This incorrect language was removed.
12 VAC 30-50-130 C			Throughout the regulation, references are changed from “skilled nursing” to “nursing” and other minor wording changes are made. C1 – Definitions were added for “Behavioral health service” and “caregiver”. The term “BHSA” was updated to “contractor” throughout the regulations, so the definition of “BHSA” was removed.

			The following terms are not used in this regulation and have been removed: "certified prescreener," "clinical experience". At the OAG's request, the definition of "child" was changed from "up to 12" to "up through 11." Definitions were added for "direct supervisor," "EPSDT," and "family support partners." The definition of "human services field" is updated to reference the DHP guidance document. The definition of LMHP was simplified. Definitions were added for "peer recovery specialist," "person-centered," QMHP-Eligible is changed to include QMHP-trainee in order to match the DBHDS definition. Definitions were added for "recovery-oriented services," "recovery, resiliency, and wellness plan," "resiliency," and "self-advocacy." A definition is removed for "services provided under arrangement" because that term is more appropriately included in paragraph D. Definitions were added for "strength-based" and "supervision." C2 and C3 – Clarifying edits were made.
12 VAC 30-50-130 D			A new paragraph D was established to contain requirements related to Therapeutic Group Homes and Psychiatric Residential Treatment Facilities. Throughout, the term is updated to "psychiatric residential treatment facility (PRTF)" for consistency. Other clarifying edits are made throughout the definitions section. Additional text is added to the definition of "assessment" and "crisis

			management" in order to match the language in the State Plan. A new definition is added for "DSM-5," "family therapy," "FAPT," "individual and group therapy," "recertification," "services provided under arrangement," and "skills restoration" in order to match the language in the State Plan. In the definition of "intervention" and in the definition of "therapeutic leave" the term "therapeutic leave" is changed to "therapeutic pass" and the text is revised in order to match the language in the State Plan. Removed definition for "psychoeducational activities," "residential case management," "residential medical supervision," and "residential supplemental therapies" as those terms are not used. D2- The language is revised in D(2) ("Therapeutic Group Home Services") in order to match the language in the State Plan. The language in D(2)(c)(4) is amended to clarify the ISP requirements ("specific to the individual s unique treatment needs and acuity levels.") Therapeutic passes are added to D(2)(c)(4)(e). Additional text on therapeutic passes is added to D(2)(c)(13) to match the language in the State Plan. D3- The language is revised in D(3) ("PRTF Services") in order to match the language in the State Plan. D4, D5, D6, D7- Text changes were made to clarify existing language. D8- Text was moved to this section from 30-50-130 B 6 (in the current VAC) so that all text about PRTFs would be in one place. VAC paragraph B6 relates to inpatient services, and although PRTFs

			are considered inpatient facilities, it was confusing to have the regulations in two different parts of 30-50-130. (Between new paragraphs E and F in 30-50-130, you will see the old text that has been stricken and moved up.) D10- This text has already been added to the VAC, and was added here to prevent "synch" issues in the Regulatory Information System.
12 VAC 30-50-130 E, F, G			E- Text about Mental Health Support Services was re-numbered from 30-50-130 B 5 f (in the current VAC) to a new paragraph E. This text has already been added to the VAC, and was added here to prevent "synch" issues in the Regulatory Information System. F - School services is re-lettered as paragraph F. G- This text has already been added to the VAC, and was added here to prevent "synch" issues in the Regulatory Information System.
12 VAC 30-50-226		This section was not in the Emergency Regulation, and has been added to the Proposed Stage regulation.	A- The following definitions were removed because they are not used in this section: Behavioral Health Services Administrator, clinical experience. The definition of "human services field" is updated to include the reference to the new DHP guidance document.
12 VAC 30-50-9999		This section was not in the Emergency Regulation, and has been added to the Proposed Stage regulation.	Updated to remove old DBHDS guidance document and include the new DHP guidance document on "Human Services Fields."
12 VAC 30-60-5 B and F		Referenced the behavioral health services administrator.	B and F- Updated to "DMAS or its contractor" to apply to any DMAS contractor (including MCOs). F- Clarifies that utilization review requirements apply to therapeutic group homes and psychiatric residential treatment facilities.
12 VAC 30-60-50			Edits made for clarification and consistency purposes.

12 VAC 30-60-61			The definition of “clinical experience” was removed as that term is not used. In the new paragraph E, subsection 2, DMAS regulations will point to the DBHDS requirements.
12 VAC 30-60			The documents incorporated by reference in 30-130-850 (which is being repealed) have been moved to 30-60-9999. An old DBHDS document is removed and replaced with a reference to the revised document.