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TO: **EMILY MCCLELLAN**
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Virginia Department of Medical Assistance Services

FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **October 2, 2018**

SUBJECT: **Fast-Track Regulations – Repeal of Virginia Independent Clinical Assessment Program (VICAP) regulations (5081/8329)**

I have reviewed the attached fast-track regulations regarding the repeal of the Virginia Independent Clinical Assessment Program ("VICAP") regulations. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to amend the regulations and if the regulations comport with state and federal law.

I have reviewed these regulations. Based on my review, it is my view that the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, under Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Under Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the Virginia Department of Medical Assistance Services shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

It is my understanding that the proposed changes do not amend the State Plan and therefore approvals for this amendment from the Centers for Medicare and Medicaid Services are unnecessary. If you have any questions, please contact me at 786-6005.

cc: Kim F. Piner, Esq.

Attachment

12VAC30-130-3000. Behavioral Health Services.

Part XVIII. Behavioral Health Services

A. Behavioral health services that shall be covered only for individuals from birth through 21 years of age are set out in 12VAC30-50-130 B 5 and include: (i) intensive in-home services (IIH), (ii) therapeutic day treatment (TDT), (iii) community based services for children and adolescents (Level A), and (iv) therapeutic behavioral services (Level B).

B. Behavioral health services that shall be covered for individuals regardless of age are set out in 12VAC30-50-226 and include: (i) day treatment/partial hospitalization, (ii) psychosocial rehabilitation, (iii) crisis intervention, (iv) case management as set out in 12VAC30-50-420 and 12VAC30-50-430, (v) intensive community treatment (ICT), (vi) crisis stabilization services, and (vii) mental health support services (MHSS).

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

12VAC30-130-3010. Definitions.

The following words and terms when used in these regulations shall have the following meanings unless the context clearly indicates otherwise:

"Behavioral health authority" or "BHA" means the local agency that administers services set out in § 37.2-601 of the Code of Virginia.

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

"Community services board" or "CSB" means the local agency that administers services set out in § 37.2-500 of the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services.

"Independent assessor" means a professional who performs the independent clinical assessment who may be employed by either the behavioral health services administrator, community services boards/behavioral health authorities (CSBs/BHAs) or their subcontractors.

"Independent clinical assessment" or "ICA" means the assessment that is performed under contract with DMAS either by the behavioral health services administrator or the CSB/BHA, or its subcontractor, prior to the initiation of (i) intensive in-home (IIH) services or therapeutic day treatment (TDT) as set out in 12VAC30-50-130 and (ii) mental health support services (MHSS) for children and adolescents (MHSS) as set out in 12VAC30-50-226.

"VICAP" means the form entitled Virginia Independent Clinical Assessment Program that is required to record an individual's independent clinical assessment information.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

12VAC30-130-3020. Independent Clinical Assessment Requirements; Behavioral Health Level of Care Determinations and Service Eligibility.

A. The independent clinical assessment (ICA), as set forth in the Virginia Independent Assessment Program (VICAP-001) form, shall contain the Medicaid individual-specific elements of information and data that shall be required for an individual younger than the age of 21 to be approved for intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) or any combination thereof. Eligibility requirements for IIH are in 12VAC30-50-130 B 5 b. Eligibility requirements for TDT are in 12VAC30-50-130 B 5 c. Eligibility requirements for MHSS are in 12VAC30-50-226 B 8.

1. The required elements in the ICA shall be specified in the VICAP form with either the BHSA or CSBs/BHAs and DMAS.

2. Service recommendations set out in the ICA shall not be subject to appeal.

B. Independent clinical assessment requirements.

1. Effective July 18, 2011, an ICA shall be required as a part of the service authorization process for Medicaid and Family Access to Medical Insurance Security (FAMIS) intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) for individuals up to the age of 21. This ICA shall be performed prior to the request for service authorization and initiation of treatment for individuals who are not currently receiving or authorized for services. The ICA shall be completed prior to the service provider conducting an intake or providing treatment.

a. Each individual shall have at least one ICA prior to the initiation of either IIH or TDT, or MHSS for individuals up to the age of 21.

b. For individuals who are already receiving IIH services or TDT, or MHSS, as of July 18, 2011, the requirement for a completed ICA shall be effective for service reauthorizations for dates of services on and after September 1, 2011.

c. Individuals who are being discharged from residential treatment (DMAS service Levels A, B, or C) or inpatient psychiatric hospitalization do not need an ICA prior to receiving community IIH services or TDT, or MHSS. They shall be required, however, to have an ICA as part of the first subsequent service reauthorization for IIH services, TDT, MHSS, or any combination thereof.

2. The ICA shall be completed and submitted to DMAS or its service authorization contractor by the independent assessor prior to the service provider submitting the service authorization or reauthorization request to the DMAS service authorization contractor. Failure to meet these requirements shall result in the provider's service authorization or reauthorization request being returned to the provider.

3. A copy of the ICA shall be retained in the service provider's individual's file.

4. If a service provider receives a request from parents or legal guardians to provide IIH services, TDT, or MHSS for individuals who are younger than 21 years of age, the service provider shall refer the parent or legal guardian to the BHSA or the local CSB/BHA to obtain the ICA prior to providing services.

a. In order to provide services, the service provider shall be required to conduct a service-specific provider intake as defined in 12VAC30-50-130.

b. If the selected service provider concurs that the child meets criteria for the service recommended by the independent assessor, the selected service provider shall submit a service authorization request to DMAS service authorization contractor. The service-specific provider's intake for IIH services, TDT, or MHSS shall not occur prior to the completion of the ICA by the BHSA or CSB/BHA, or its subcontractor.

c. If within 30 days after the ICA a service provider identifies the need for services that were not recommended by the ICA, the service provider shall contact the independent assessor and request a modification. The request for a modification shall be based on a significant change in the individual's life that occurred after the ICA was conducted. Examples of a significant change may include, but shall not be limited to, hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent or legal guardian.

d. If the independent assessment is greater than 30 days old, a new ICA must be obtained prior to the initiation of IIH services, TDT, or MHSS for individuals younger than 21 years of age.

e. If the parent or legal guardian disagrees with the ICA recommendation, the parent or legal guardian may appeal the recommendation in accordance with Part I (12VAC30-110-10 et seq.) In the alternative, the parent or legal guardian may request that a service provider perform his own evaluation. If after conducting a service-specific provider intake the service provider identifies additional documentation previously not submitted for the ICA that demonstrates the service is medically necessary and clinically indicated, the service provider may submit the supplemental information with a service authorization request to the DMAS service authorization contractor. The DMAS service authorization contractor will review the service authorization submission and the ICA and make a determination. If the determination results in a service denial, the individual, parent or legal guardian, and service provider will be notified of the decision and their appeal rights pursuant to Part I (12VAC30-110-10 et seq.).

5. If the individual is in immediate need of treatment, the independent clinical assessor shall refer the individual to the appropriate enrolled Medicaid emergency services providers in accordance with 12VAC30-50-226 and shall also alert the individual's managed care organization.

C. Requirements for behavioral health services administrator and community services boards/behavioral health authorities.

1. When the BHSA, CSB, or BHA has been contacted by the parent or legal guardian, the ICA appointment shall be offered within five business days of a request for IIH services and within 10 business days for a request for TDT or MHSS, or both. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian.

2. The independent assessor shall conduct the ICA with the individual and the parent or legal guardian using the VICAP-001 form and make a recommendation for the most appropriate medically necessary services, if indicated. Referring or treating providers shall not be present during the assessment but may submit supporting clinical documentation to the assessor.

3. The ICA shall be effective for a 30-day period.

4. The independent assessor shall enter the findings of the ICA into the DMAS service authorization contractor's web portal within one business day of conducting the assessment. The independent clinical assessment form (VICAP-001) shall be completed by the independent assessor within three business days of completing the ICA.

~~D. The individual or his parent or legal guardian shall have the right to freedom of choice of service providers.~~

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

~~12VAC30-130-3030. Application to Services.~~

~~A. Intensive in-home (IIH) services.~~

~~1. Prior to the provision of IIH services, an independent clinical assessment shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is either employed by or contracted with a behavioral health services administrator (BHSA), community services board (CSB), behavioral health authority (BHA), or a subcontractor to the BHSA, CSB, or BHA in accordance with DMAS approval.~~

~~2. IIH services that are rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.~~

~~B. Therapeutic day treatment (TDT) services.~~

~~1. Prior to the provision of TDT services, an independent clinical assessment shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is employed by or contracted with a BHSA, CSB, BHA, or the subcontractor of the BHSA, CSB, or BHA in accordance with DMAS approval.~~

~~2. TDT services that are rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.~~

~~C. Mental health support services (MHSS).~~

~~1. Prior to the provision of MHSS, an independent clinical assessment, as defined in 12VAC30-130-3010, shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is employed by or contracted with a BHSA, CSB or BHA, or a subcontractor of a BHSA, CSB, or BHA in accordance with DMAS approval.~~

~~2. MHSS rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.~~

~~D. Other Medicaid-covered community mental health services. DMAS may apply the independent clinical assessment requirement to any of the other Medicaid-covered community mental health services set out in 12VAC30-50-130 and 12VAC30-50-226 with appropriate and timely notice to providers. In such situations, DMAS shall not deny coverage to providers' claims for these affected services absent at least a 30-day notice of this change.~~

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.