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Fast-Track Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 30-60-5; 12 VAC 30-60-140
VAC Chapter title(s)	Applicability of utilization review requirements; Community mental health services
Action title	Service Authorization
Date this document prepared	9/15/2021

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code.*

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This Fast Track action follows an Emergency Regulation that clarified the documentation requirements for service authorization including service authorization for Community Mental Health and Rehabilitative Services. There are slight changes between the text in this regulation and the text in the Emergency Regulation.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

BHSA = Behavioral Health Services Administrator
CMHS = Community Mental Health and Rehabilitative Services
DMAS = Department of Medical Assistance Services

Statement of Final Agency Action

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.

On September 15, 2021, DMAS adopted final amendments to the regulatory action entitled, "Service Authorization."

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

Consistent with Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track rulemaking process.

The Code of Virginia § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

This action is expected to be non-controversial because the changes in the emergency regulation are a re-organization of requirements that were already in place. The ER/NOIRA public comment period generated no comments.

The changes between the ER/NOIRA and this Fast Track stage are also non-controversial. The first change requires providers to submit records to DMAS without delay when they are requested. This requirement is already contained in the provider enrollment agreement that is signed by each provider prior to offering Medicaid services. Another change removes the phrase "unless specified otherwise" because the requirement applies to all services. A further new item states that claims selected for utilization review cannot be corrected or re-billed. This is current practice and is not a change for providers. An additional change reflects changes to the wording made based on public comment during the public posting of the Mental Health Services Manual.

In addition, the word "individual" has been changed to member to ensure consistency in the regulatory text. Several wording changes were made for clarity and to reflect current practice, as detailed in the chart at the end of this document.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The Code of Virginia § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

This regulation is essential to protect the health, safety, or welfare of citizens in that it ensures that Medicaid members receive appropriate services based on their documented needs. This action meets the budget mandate because it ensures proper utilization and cost efficiency.

Substance

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.

This regulatory action is a re-organization of the documentation requirements for service authorization including service authorization for Community Mental Health and Rehabilitative Services. The first change states that providers should maintain documentation to support claims for reimbursement, while the second change requires providers to submit records to DMAS upon demand. Both of these items are already contained in the provider enrollment agreement that is signed by each provider prior to offering Medicaid services. Another new item states that claims selected for utilization review cannot be corrected or re-billed. This is current practice and is not a change for providers.

Changes made between the emergency regulation and this Fast Track stage also include a requirement that providers submit records to DMAS without delay when they are requested, and the requirement that claims selected for utilization review not be corrected or re-billed. These requirements are current practice and are not a change for providers.

Issues

Identify the issues associated with the regulatory change, 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, include a specific statement to that effect.

The primary advantage of this regulation to the public and the Commonwealth is that it ensures that Medicaid members receive appropriate health care services based upon their documented needs. There are no disadvantages to the Agency, the public, or the Commonwealth.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and 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 specific statement to that effect.

There are no requirements in this regulation that are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as tribal governments, school boards, community services boards, and similar regional organizations. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

No other state agencies, localities, or other entities are particularly affected by this regulation.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail;	None.

b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	
For other state agencies: projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	None.
For all agencies: Benefits the regulatory change is designed to produce.	This regulation clarifies the documentation requirements for service authorization including service authorization for Community Mental Health and Rehabilitative Services.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	None.
Benefits the regulatory change is designed to produce.	This regulation clarifies the documentation requirements for service authorization including service authorization for Community Mental Health and Rehabilitative Services.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	All Medicaid providers.
Agency's best estimate of the number of such entities that will be affected. 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.	Most Medicaid providers except hospitals and hospital-owned entities are small businesses.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	None.
Benefits the regulatory change is designed to produce.	This regulation clarifies the documentation requirements for service authorization including service authorization for Community Mental Health and Rehabilitative Services.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. 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 regulatory change.

This regulatory action provides guidance for providers on utilization review requirements. This material is contained in Medicaid Manuals, and in the provider enrollment agreement, but DMAS seeks to also establish clarity and a legal basis for utilization review through regulations.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, 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) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing 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 regulatory change.

This regulatory action provides guidance for providers on utilization review requirements. This material could be contained in Medicaid Manuals instead of regulations, but the manuals generally have less legal weight than Medicaid Manuals. As a result, DMAS seeks to establish clarity and a legal basis for utilization review through regulations.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

Consistent with § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-day 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 agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please also indicate the nature of, and reason for, your objection to using this process.

DMAS is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Emily McClellan, DMAS, 600 E. Broad Street, Richmond, VA 23219, 804-371-4300, or Emily.McClellan@dmas.virginia.gov In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

Changes made in Emergency Regulation:

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
12 VAC 30-60-5-A			An introductory paragraph was added to clarify the utilization control measures used by DMAS.
12 VAC 30-60-5 B			Definition of “service authorization” added to text.
12 VAC 30-60-5 B1			Clarifies that in order to obtain service authorization, information shall be provided to support that the service is medically necessary.
12 VAC 30-60-5 B2			The sentence was re-written for clarity and to link the requirement back to the ”service authorization” heading.
12 VAC 30-60-5 B3			Text added related to requests for continued service authorization.
12 VAC 30-60-5 C			This paragraph is no longer needed due to the new introductory paragraph in A.
12 VAC 30-60-5 D			Paragraph re-lettered as “C.” DMAS contractors are added to reflect current practice. DMAS laws, regulations, and provider agreement requirements added as compliance components.
12 VAC 30-60-5 E			Paragraph re-lettered as “D.” DMAS laws, regulations, and provider agreement requirements added as compliance components.
12 VAC 30-60-5 F		Section F relates to community mental health services, and does not belong in this section, which relates to utilization review for all services. This content was moved to 12VAC30-60-140.	The content of paragraph F3 – provisional licenses – was moved to 140 D 5. The content of paragraph F3 -- provider enrollment contract – was moved to 140 D 6. The content of paragraph F4 was moved to 140 B1. The content of paragraph F5 was removed to avoid duplication with DHP

			regulations that have requirements for how a resident or supervisee should sign their names.
12 VAC 30-60-140 A			An introductory paragraph was added to clarify the utilization control measures used by DMAS for community mental health services.
12 VAC 30-60-140 B			Requirements for initial and continuing service authorization requests are clarified.
12 VAC 30-60-140 C and D			Paragraphs re-lettered.
12 VAC 30-60-140 C			Removed the phrase “at a minimum annually” to reflect current practice.
12 VAC 30-60-140 D 5 and D 6			Licensure and enrollment rules that were in 12VAC30-60-5 were moved here.

Changes made between Emergency Regulation and Fast Track:

Througout			The word “individual” was changed to “member” for consistency.
12 VAC 30-60-5 B			Removed “FAMIS Plus” and replaced the word “individual” with “member”
12 VAC 30-60-5 B(2)			The phrase “unless specified otherwise” was removed because the requirement applies to all services.
12 VAC 30-60-5 B(3)			Changed “ISP” to “individual service plan or related document, if one is required”
12 VAC 30-60-5 (E)			Added “guidance documents” to the list of provider standards and changed the word “comport” to “comply” for clarity.
12 VAC 30-60-5 (F)			Added “guidance documents” to the list of provider standards
12 VAC 30-60-5 D			A new paragraph D contains the requirements that records be provided without delay upon request and that claims selected for utilization review not be corrected or re-billed.
12 VAC 30-60-140 B 1 and B 2			Changes were made to reflect changes to this language made based on public feedback during the public posting of the Mental Health Services Manual. The changes are: B1. (iii) demonstrate individualized preliminary ~~and comprehensive~~ treatment planning and initial conceptualization of goals.

			2. Continued authorization requests shall include the documentation requirements in subdivision 1 of this subsection, as well as demonstrate individualized and comprehensive treatment planning, documentation of the individual's current status and the individual's progress, or lack of progress, toward goals and objectives in the ISP and documentation of discharge planning.
12 VAC 30-60-140 D 3			Replace “Amount Duration and Scope of Services” with “mental health service regulations”
12 VAC 30-60-140 D 5			This language was corrected as it only applies to providers required to have a Department of Behavioral Health and Developmental Services license. The changes are: 5. ~~To qualify as a Medicaid provider of community~~ For mental health services that require a Department of Behavioral Health and Developmental Services (DBHDS) license, the provider must have a full, annual, triennial, or conditional license from ~~the Department of Behavioral Health and Developmental Services~~ DBHDS. Health care entities with provisional licenses shall not be reimbursed as Medicaid providers of ~~community~~ mental health services.
12 VAC 30-60-140 D 6			Removed the word “enrollment” for clarity.