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MEDICAID MEMO

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Changes to Community Mental Health Rehabilitative Services – Final Regulations Pertaining to all Community Based Services with the Exception of Mental Health Skill-Building Services

The purpose of this memorandum is to reiterate important changes to Community Mental Health Rehabilitative Services (CMHRS) that became effective January 30, 2015. The changes being implemented are due to the approval of final regulatory changes that were developed and shared with stakeholder groups from 2011 through 2013. DMAS collected public comments on the regulations from August to September, 2011 and again from February through April, 2013. The final regulatory changes were based on the changes defined in the Emergency Regulation package that was in effect from July 18, 2011 through January 16, 2013. The previous Emergency Regulations package defined most of the changes that these final regulations incorporate into the administrative code. The text of the regulations and these changes has been publicly available on the Virginia Regulatory Town Hall since June, 2014. Providers can find the final regulations (including the changes) on the Virginia Regulatory Town Hall at http://townhall.virginia.gov/L/ViewXML.cfm?textid=9322. It is important that providers review the regulations to ensure compliance.

Summary of CMHRS Changes

The chart below summarizes the changes to the CMHRS regulations. The changes are listed for each affected Virginia Administrative Code section.

Section Number	Change and Rationale

12 VAC 30-50-130	A new comprehensive definition section is added. This section includes detail on staff qualifications and requirements for various types of documentation. Professional personnel definitions correlate to licensing standards established by DBHDS, DSS or DOJ, as appropriate for the provider type. Provisional licenses will no longer be permitted. Care coordination between different providers is required and must be documented.

	Care Coordination serves to help align services and is intended to complement the service planning and delivery efforts for case management. Service authorization is required prior to the onset of services. Case management is removed from IIH due to a federal requirement in 42 CFR § 441.18. The service definition is revised to provide for care coordination which will be called “service coordination” and will include activities designed to implement treatment goals by the service provider. Care coordination/service coordination is a required component of Level A and Level B services.

12 VAC 30-50-226	A new comprehensive definitions section is added. This section includes detail on staff qualifications and requirements for various types of documentation. Providers must meet licensing standards required by DBHDS in order to claim Medicaid reimbursement. Professional personnel definitions correlate to licensing standards established by DBHDS, DSS or DOJ, as appropriate for the provider type. Service-specific provider intakes must be completed by LMHP's and are required for all services. Intakes must reference past interventions by the mental health, social services, or judicial system that have been documented. Re-assessment is required to determine medical necessity and authorize continued services. Case management is being removed from ICT due to a federal requirement in 42 CFR § 441.18. The service definition was revised to provide for care coordination which will be called "service coordination" and will include activities designed to implement treatment goals by the service provider. Crisis intervention services require registration with DMAS or the Behavioral Health Services Administrator (BHSA).
12 VAC 30-60-5	Provides utilization review requirements for all Medicaid covered services. Provisional licenses are prohibited and DMAS provider enrollment agreements are required. Reimbursement that is not supported by required provider documentation is subject to retraction by DMAS.
12 VAC 30-60-61	A new definition section is added that includes definitions of "at risk," "failed services," and "out of home placement." Specific data elements are required to ensure uniform and complete intakes. Documentation requirements are established for IIH services that occur outside the home. LMHPs will be required to conduct IIH/TDT service specific provider intakes due to

	the acute nature of the services. Requirements are added for service notifications to case managers and primary care providers. Provision is made for service authorizations when temporary lapses of service occur. Specific prohibition against providers copying the same progress notes from day to day. Provider documentation and supervision requirements are established. Marketing guidelines are intended to reduce/preclude inappropriate marketing activities by potential providers.
12 VAC 30-60-143	Service-specific provider intakes and Individual Service Plans must be completed by certain professional license levels. Services must be provided by certain license levels. Coordination with case manager and primary care provider is required.
12 VAC 30-130-2000	Rules are established to control how providers will be permitted to market their services to potential Medicaid clients.
12 VAC 30-130-3000	Defines which services are only available to individuals under the age of 21.
12 VAC 30-130-3010	A new definition section related to the Independent Clinical Assessment (ICA).
12 VAC 30-130-3020	New rules establish requirements and applicability of the ICA. Services will not be reimbursed if a required ICA is not performed.
12 VAC 30-130-3030	Lists services that require an ICA.

Provider Questions

In the weeks since the regulations have become effective, providers have raised several questions, which are answered below.

These questions are:

1. Can private providers be reimbursed for Crisis Intervention Services?

ANSWER: Yes. The new DMAS regulations require providers to be licensed as Emergency Services providers. This requirement will not prevent providers who are already providing crisis intervention services, and who hold an Outpatient Services license, from providing Crisis Intervention services and receiving Medicaid reimbursement. Providers who are not currently providing Crisis Intervention services, but are interested in doing so, will work with DBHDS to first obtain the appropriate license.

2. Should IIH and ICT providers stop providing case management services?

ANSWER: Yes. As a result of federal requirements, the new DMAS regulations prohibit IIH and ICT providers from including case management as a component of those services. Instead, providers will offer service coordination, which is less intensive. Many individuals who are receiving IIH or ICT will continue to need case management services, and must be referred to their Community Service Board for this service.

3. Are the staff qualifications in the regulations currently in effect?

ANSWER: Yes. The staff qualifications went into effect on January 30, 2015. DMAS worked closely with the Department of Behavioral Health and

Developmental Services and the Department of Health Professions to ensure that DMAS requirements align with the provider and practitioner licensing requirements issued by these agencies. These changes were subject to public comment. In addition, DMAS discussed LMHP and QMHP staff qualification issues with providers regularly as these regulations were being developed and promulgated. (As a result, additional types of LMHPs and QMHPs are permitted to provide services.)

4. Will the new regulations affect documentation requirements?

ANSWER: Yes. Documentation in the clinical record must be in compliance with and reflect the new regulatory language, consistent with the effective date of these regulations. Additionally, documentation submitted for service authorization will be validated within the clinical record upon post payment review. Inconsistencies may be subject to retraction and/or referral to the Medicaid Fraud Control Unit (MFCU) within the Office of Attorney General.

EDUCATION AND OUTREACH

A Magellan Provider Webinar is scheduled for April 2, 2015 at 1pm to provide an overview of the CMHRS program changes. Additionally there will be four in-person training sessions scheduled for dates during the spring to discuss detailed program changes and the revised program manuals. To find details on all upcoming trainings please refer to: http://magellanofvirginia.com/for-providers-va/training.aspx.

Information regarding upcoming trainings will be posted to the DMAS and Magellan of Virginia websites. Recorded trainings will also be posted to both websites. Additional online training resources will be announced once the effective dates are finalized.

General questions regarding the CMHRS program may be e-mailed to CMHRS@dmas.virginia.gov or VAProviderQuestions@magellanhealth.com.

Current MHSS Rules

DMAS has become aware that there is some confusion regarding these final regulations and the Emergency Regulations for Mental Health Skill Building Services. There is some structural overlap between these two regulatory packages. However, these are two separate regulatory packages, and each remains in effect.

The current MHSS Emergency Regulations can be found in the Virginia Town Hall website at: http://townhall.virginia.gov/L/ViewStage.cfm?stageid=6725.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Service Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4536 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a new program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx to learn more.

MANAGED CARE ORGANIZATIONS

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access medical and pharmacy information, GAP member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866- 352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800- 772-9996. Both options are available at no cost to the provider.

Additional information regarding medical service authorization information may be found at http://dmas.kepro.com or http://www.dmas.virginia.gov/content_pgs/pa-home.aspx. Providers may also access service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.com.

MEDICAL AND PHARMACY "HELPLINE"

The DMAS "HELPLINE" is available to answer medical and pharmacy questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you