



Department of Medical Assistance Services
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MEDICAID MEMO

TO: Providers of Community Mental Health Rehabilitative Services and Managed Care Organizations

FROM: Cynthia B. Jones, Acting Director
Department of Medical Assistance Services

MEMO: Special

DATE: July 23, 2010

SUBJECT: Changes to Children Community Mental Health Rehabilitative Services — **Children’s Services, July 1, 2010 & September 1, 2010 This memo replaces the Changes to Community Mental Health Rehabilitative Services Memo dated June 9, 2010.**

DMAS is releasing this revised replacement memo to clarify the June 9th memorandum. This provider memo addresses only children’s services.

Effective July 1, 2010 and also, September 1, 2010, DMAS will implement new requirements for Children’s Community Mental Health Rehabilitative Services (also referred to as state plan option services). Community Mental Health Rehabilitative Services (CMHRS), specifically intensive services, are provided for children and adolescents imminently at risk for out-of-home placement to acute care, foster care, or residential care. As the needs of these children and their families are complex, DMAS wants to ensure that services are provided by providers who are educationally and clinically prepared to deliver the interventions. The changes include new requirements for service delivery and adherence to DMAS marketing/outreach rules. These changes are made to ensure quality services for children who receive Medicaid or FAMIS reimbursed services. DMAS worked in collaboration with the Department of Behavioral Health and Developmental Services (DBHDS) and public and private stakeholders to develop and clarify these important changes. The specific changes are described below. Providers are expected to comply with the changes within the specified time frames or they will not be eligible for Medicaid participation and reimbursement.

This Medicaid Memo also announces other requirements that will be effective on September 1, 2010. Providers will have six (6) months to comply with the September 2010 provider qualification changes. If staff are not in compliance with the new qualifications by March 1, 2011, the services provided by them will not be eligible for Medicaid participation and reimbursement.

Changes Effective July 1, 2010

DMAS will adopt new caseload size and supervision requirements for the following services:

1. Intensive In-Home (IIH) (H2012)

Caseload

- a. The caseload cannot exceed five clients per Qualified Mental Health Professional (QMHP). If a family is transitioning out of Intensive In-Home Services, the caseload may be 1:6 for up to 30 calendar days.

Supervision

- b. A Licensed Mental Health Professional (LMHP) or a license-eligible mental health professional must provide clinical supervision at regular intervals. The full-time (regularly scheduled, 32 hours or more per week) LMHP or the license-eligible mental health professional can supervise up to 10 staff; half-time (regularly scheduled, 16 to 31.9 hours per week) supervisors can supervise up to five (5) supervisees. If a supervisor works less than half time, the supervision limit is two (2) counselors.
License-eligible is defined as an individual who has completed his or her graduate degree and is under the direct personal supervision of an individual licensed under Virginia state law. The individual must be working towards licensure and must be registered with the appropriate Virginia Licensing Board.
- c. LMHP or a license-eligible mental health professional must provide clinical supervision weekly, with individual face to face supervision occurring at least every other week. Group supervision may occur on the other weeks. Weekly supervision is not required when the supervisor is on leave for up to two weeks at a time. If the supervisor is on leave for one episode that is more than two weeks, a substitute supervisor must provide clinical supervision.
- d. A clinical supervisor (LMHP or a license-eligible mental health professional) must be available for face to face or phone consultation when services are being provided.
- e. Supervision must be documented by the LMHP or a license-eligible mental health professional providing the supervision activity. A supervision log or note must be placed in the client's file documenting that supervision was provided. A more detailed note written by the supervisor summarizing the meeting and noting any recommendations must be maintained in a separate supervisor's file.
- f. LMHPs or a license-eligible mental health professional must provide clinical supervision. A QMHP can only provide administrative supervision

Assessments

- g. The assessment (H0031) must include the elements specified by DMAS. Please see Attachment A, which outlines the required thirteen (13) elements.
- h. The assessment for Intensive In-Home services must be conducted in the child's home unless there is a documented safety or privacy issue.

Prior Authorization

- i. As of July 1, 2010, providers must request prior authorization for Intensive In-Home Services (H2012) before providing treatment services. The assessment will continue to be allowed and reimbursed without prior authorization. The allowance for units of service without prior authorization will be discontinued.

2. Day Treatment for Children and Adolescents (H0035HA)

The assessment (H0032, U7) must include the thirteen (13) elements specified by DMAS. Please see Attachment A, which outlines the required elements.

3. Community-Based Residential Services for Children and Adolescents Under 21- Level A (H2022 HW (CSA); H2022 HK (Non-CSA)) and Therapeutic Behavioral Services - Level B (H2020 HW (CSA); H2020 HK (Non-CSA))

The Virginia Child and Adolescent Needs and Strengths Assessment (CANs) will continue to be used for CSA children. Assessments for non-Comprehensive Services Act (CSA) children must include all

the thirteen (13) elements specified by DMAS. Please see attachment A that outlines the required elements.

4. *Marketing and Outreach*

Providers of all community mental health and substance abuse services are required to adhere to DMAS marketing and outreach requirements. Please see Attachment C for details on this requirement.

5. *Case Management/Primary Care Provider Coordination*

For all community mental health rehabilitative services that allow concurrent provision of case management, the service provider must collaborate with the case manager and provide notification of the provision of services. In addition, the service provider must send monthly updates to the case manager on the client's progress. A discharge summary must be sent to the case manager within 30 days of the service discontinuation date. Case management can be provided through Intensive In-Home services, Treatment Foster Care Case Management, mental health or intellectual disability/mental retardation case management from a Community Services Board, or case management for clients with developmental disabilities who are eligible for or receiving services through the Individual and Family Developmental Disabilities Support Waiver. Only one type of case management can be provided at a time. Because Intensive In-Home services include case management activities as a component of the service, the requirement for the case manager to send updates and discharge summaries does not apply to this service.

The service provider must also inform the primary care provider or pediatrician of the child's receipt of community mental health rehabilitative services.

6. *Manual Changes*

These changes are reflected in the July 2010 revision of the Community Mental Health Rehabilitative Services Manual which is posted on the DMAS website.

7. *Managed Care Organizations (MCOs)*

Medicaid managed care organizations will be receiving utilization information from DMAS on the Community Mental Health Rehabilitative Services utilized by their members. Providers of Community Mental Health Rehabilitative Services may be contacted by the managed care organizations to discuss the care of these children.

Changes Effective Sept. 1, 2010

The following changes are effective September 1, 2010. Advance notice is provided to allow providers time to comply with the new requirements.

1. *Service Requirements*

Intensive In-Home, Day Treatment for Children and Adolescents, Community-Based Residential Services for Children and Adolescents Under 21 (Level A) and Therapeutic Behavioral Services (Level B):

- a. A LMHP or a license-eligible mental health professional must make the diagnosis.
- b. A LMHP or a license-eligible mental health professional must perform the assessment. If a license-eligible professional performs the assessment, the assessment must be reviewed with the

LMHP within 24 hours of conducting the assessment to collaboratively determine the client's diagnosis.

Day Treatment for Children and Adolescents (H0035HA)

- c. The description of allowed activities is revised. Medicaid will only reimburse for direct service activities. Time not actively involved in providing services directed by the Individualized Service Plan (ISP) is not allowed. This means indirect services (time not spent working with the child or on behalf of the child) are not allowed to be billed for Medicaid reimbursement. Allowed services include consultation with teachers and others involved in the child/adolescent's treatment and observation in the classroom. Please see Attachment B for full guidance on this subject.
- d. The caseload for the direct service provider is a maximum of six (6) children per day.
- e. Paraprofessionals may not provide services for Day Treatment for Children and Adolescents. Paraprofessionals are still allowed providers for Levels A & B Community-Based Residential Services.

2. Qualifications for QMHP

Intensive In-Home, Day Treatment for Children and Adolescents, Community-Based Residential Services for Children and Adolescents Under 21 (Level A) and Therapeutic Behavioral Services (Level B):

The effective date for the following staff qualification changes will be Sept. 1, 2010, but providers are given until March 1, 2011 (6 months) for all existing staff to comply with the regulatory change. Any staff person hired or rehired on or after September 1, 2010, must meet the following requirements in order to provide Intensive In-Home, Day Treatment for Children and Adolescents, Community-Based Residential Services for Children and Adolescents Under 21 (Level A) and Therapeutic Behavioral Services (Level B):

- a. To qualify as a QMHP to provide Intensive In-Home, Day Treatment for Children and Adolescents, Community-Based Residential Services for Children and Adolescents Under 21 (Level A) and Therapeutic Behavioral Services (Level B), the individual must have the designated clinical experience and must:
 - i. be a physician; or
 - ii. have master's degree in psychology from an accredited college or university with at least one year of clinical experience; or
 - iii. have a social work bachelor's or master's degree from an accredited college or university with at least one year of clinical experience with children or adolescents; or
 - iv. be a registered nurse with at least one year of clinical experience with children and adolescents; or
 - v. have at least a bachelor's degree in a human services field or in special education from an accredited college and with at least one year of clinical experience with children and adolescents.

Clinical experience means providing direct clinical services to children and adolescents with mental illness. It includes supervised internships, practicums, and field experience. A human services field is defined as social work, psychology, sociology, or counseling.

Variance Process

A variance process was established jointly with the Department of Behavioral Health and Developmental Services (DBHDS) to approve qualified persons with a bachelor's degree in an unrelated field. Considerations will include history of coursework in the human services fields, experience with children with mental health or substance abuse issues, and the ability of the employing organization to provide supervision.

- b. For children's services, persons with the following qualifications will be allowed to continue to provide services as a QMHP as long as the person stays in the same position with their same employer of record as of September 1, 2010 and has the required experience as defined above and:
 - i. A bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field and three years clinical experience; or
 - ii. A bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent credits based on a trimester system) in a human services field and three years clinical experience.
- c. In order to allow providers to develop QMHP staff, a new QMHP eligible category will be created, effective September 1, 2010. This category is created to allow staff with a bachelor's degree the ability to provide services and gain clinical experience under supervision. Staff must have the following credentials:
 - i. At least a bachelor's degree in a human services field or in special education from an accredited college without one year of clinical experience; or
 - ii. A bachelor's degree from an accredited college in an unrelated field and is enrolled in a Master's or Doctoral clinical program and is actively taking at least 3 credits per semester.

Only one QMHP eligible staff will be allowed for each full time licensed staff. The number of QMHP eligible staff will not exceed five (5) percent of total clinical child staff in the agency. The QMHP eligible staff must have at least one hour of LMHP supervision per week which must be documented in the supervisor's file. The QMHP eligible staff must also participate in monthly training which must also be documented in the staff file. The monthly training can not be duplicative of supervision time. Evidence of compliance with the QMHP eligible criteria must be in the staff's personnel file.

The employing agency must have a triennial license from the DBHDS and have a DMAS and DBHDS approved supervision training program. The procedures for applying for approval of the supervision training program will be published on the DMAS website by September 1, 2010.

QMHP Staff Variance

- d. Until February 11, 2011, a provider may request a variance for staff who have a bachelor's degree in an unrelated field without sufficient human services credits or who do not have a bachelor's degree but who have at least four years experience in providing children's behavioral health services. A provider may not have more than 20% of their total children's clinical (direct service) staff qualify as a QMHP by this method. Variances will be submitted to DMAS and evaluated with consultation from DBHDS. The variances will be granted based on the type and years of experience, agency licensure status, continuing education, and the ability of the provider to provide clinical and administrative supervision. Procedures for requesting a variance are posted on the DMAS website

at http://dmasva.dmas.virginia.gov/Content_atchs/obh/pr-obh_vps.pdf . Questions about or requests for variances may be submitted to CMHRSvariance@dmas.virginia.gov beginning July 15, 2010. DMAS will respond within ten (10) business days. If a variance request is approved by DMAS, this documentation must be maintained in the personnel file of the staff person who received the variance. The variance remains in effect as long as the staff person remains in the same job with the same employer. Requests for variance will not be accepted after February 11, 2011.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check 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 ACS 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.

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices are no longer printed and mailed free of charge. Duplicate remittance advices are now processed and sent via secure email. A processing fee for generating duplicate paper remittance advices has been applied to paper requests, effective July 1, 2009.

ALTERNATE METHODS TO LOOK UP INFORMATION

As of August 1, 2009, DMAS authorized users now have the additional capability to look up service limits by entering a procedure code with or without a modifier. Any procedure code entered must be part of a current service limit edit to obtain any results. The service limit information returned pertains to all procedure codes used in that edit and will not be limited to the one procedure code that is entered. This is designed to enhance the current ability to request service limits by Service Type, e.g., substance abuse, home health, etc. Please refer to the appropriate Provider Manual for the specific service limit policies.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666
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COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the “DMAS Content Menu” column on the left-hand side of the DMAS web page for the “Provider Services” link, which takes you to the “Manuals, Memos and Communications” link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

“HELPLINE”

The “HELPLINE” is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state 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 call.

Attached Number of Pages: (6)

**Assessment Items for DMAS Reimbursed Intensive In-Home, Day Treatment for Children and Adolescents, and Levels A & B Community Residential Services
Attachment A**

1. **Presenting Issue(s)/Reason for Referral:** Chief Complaint. Indicate duration, frequency and severity of behavioral symptoms. Identify precipitating events/stressors, relevant history.) If child is at risk of out of home placement, state specific reason
2. **Mental Health History/Hospitalizations:** Give details of mental health history and any mental health related hospitalizations and diagnoses, including List the types of interventions that have been provided to the child/family. Include the date of the interventions and the name of the provider. List family members and the dates and the types of treatment that family members either are currently receiving or have received in the past.
3. **Medical Profile:** Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. **Individualized Fall Risk Assessment:** Does client have any physical conditions or other impairments that put her/him at risk for falling For children 10 years or younger, the risk should be greater than that of other children the same age.
4. **Developmental History:** Describe client as an infant & toddler: child's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and parents ability to provide these; parents feelings/thoughts about child as an infant and toddler. Was the client significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?
5. **Educational/Vocational Status:** School, grade, special ed./IEP status, grades, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, peer relationships
6. **Current Living Situation and Family History and Relationships:** Daily routine & structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting client and family's functioning list all family members.
7. **Legal Status:** Indicate client's criminal justice status. Pending charges, court hearing date, probation status, Past convictions, current probation violations, past incarcerations
8. **Drug and Alcohol Profile:** Substance use / abuse of client / family members. Type of Substance, Frequency/Duration
9. **Resources and Strengths:** Verbalize child/family strengths. Extracurricular activities, church, extended family
10. **Mental Status Profile:**
11. **Diagnosis:** Diagnosis- Includes DSM-IV Code & Description:
12. **Professional Assessment Summary/ Clinical Formulation:** Documentation of the need for services.
13. **Recommended Treatment Goals:**

Day Treatment Description **Attachment B**

Allowed Activities:

- Completing diagnostic evaluations, assessing treatment needs;
- Planning and implementing individualized pro-social skills curriculums and interventions;
- Monitoring progress in demonstrating the acquisition of pro-social skills (anger management, problem-solving skills, identification and appropriate verbalization of feelings, conflict resolution, etc.);
- Implementing cognitive-behavioral programming;
- Planning and implementing individualized behavior modification programs and monitoring progress through collaboration with school personnel, family, and others involved in the child/adolescent's treatment;
- Responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day;
- Providing individual, group, and family counseling based on specific treatment objectives; and
- Collaborating with all other community practitioners providing services to the child/adolescent, including scheduling appointments and meetings.

Activities that are not Allowed:

- Inactive time or time spent waiting to respond to a behavioral situation;
- Transportation; and
- Time spent in documentation of client and family contacts, collateral contacts, and clinical interventions.

**MARKETING AND PROMOTIONAL MATERIAL/ACTIVITY
REQUIREMENTS
FOR CMHRS SERVICES**

Attachment C

“Marketing Materials and Services” activities as defined shall apply to Medicaid/FAMIS/FAMIS Plus beneficiaries who may or may not be currently enrolled with the Provider. Beneficiaries include children under the age of 21 and their families using CMHRS services. All Providers may utilize subcontractors for marketing purposes; however, Providers will be held responsible by the Department of Medicaid Assistance Services (“Department”) for the marketing activities and actions of subcontractors who market on their behalf.

Marketing and promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws, when applicable. Providers that market services to beneficiaries or to those interested in enrolling must provide clear, written descriptions of the Medicaid mental health service, eligibility requirements for the service, service limitations, fees and other charges, and other information necessary for beneficiaries and their families to make an informed decision about enrollment into the service.

Providers must distribute marketing materials only to the potentially eligible beneficiaries based on the service locations approved within the license issued by the Licensing Division of the Department of Behavioral Health and Developmental Services.

1. Prohibited Marketing and Outreach Activities

The following are prohibited marketing and outreach activities for CMHRS services:

- a. Engaging in any informational or marketing activities which could mislead, confuse, or defraud beneficiaries or misrepresent the service or the Department.
- b. Conducting door-to-door, telephonic, or other “cold call” marketing directed at prospective or current beneficiary residences.
- c. Conducting marketing outreach efforts directed at provider sites, day care, community organizations, church or other faith-based organizations, other social networking groups, health fairs, or school sites, unless approved by the Department through its marketing plan.
- d. Making home visits for direct marketing or enrollment activities except when requested by the beneficiary.

- e. Offering discounts or cash incentives, rewards, gifts, or other opportunities to potentially eligible beneficiaries as an inducement to enroll in the Provider's service.
- f. Continuous, periodic marketing activities to the same prospective beneficiary, e.g., monthly or quarterly give-aways, as an inducement to enroll.
- g. Using Medicaid protected health information (PHI) provided by another entity (including, but not limited to, a school system) to identify and market its plan to prospective beneficiaries, or any other violation of confidentiality involving sharing or selling beneficiary lists or lists of eligibles with any other person or organization for any purpose other than the performance of the Provider's obligations under its provider agreement.
- h. Contacting beneficiaries who choose to disenroll from the Provider after the effective disenrollment date except as required by the Department.
- e. Conducting service assessment or enrollment activities at any marketing, community, or other event.
- f. Asserting or stating (whether written or oral) that the Provider is endorsed by the Centers for Medicare and Medicaid Services (CMS); Department of Medical Assistance Services; Federal or State government; or similar entity.
- g. Offering rebates or other cash inducements of any sort to beneficiaries or individuals or organizations that refer beneficiaries to the Provider.
- h. Asserting or stating that the beneficiary must enroll with the Provider in order to keep him/her from losing Medicaid/FAMIS Plus benefits.
- i. Collecting Medicaid/FAMIS Plus ID numbers, addresses, or names to be used for marketing purposes.
- j. Offering of free, non-cash promotional items and "give-aways" that exceed a total combined nominal value of \$25.00 to any prospective or enrolled beneficiary or family for marketing or beneficiary retention purposes. Items that do not promote health (such as, but not limited to cigarettes) should not be used.

To ensure compliance with these requirements, the Provider shall:

- a. Submit to the Department a complete marketing plan if marketing is conducted. This applies to marketing plans in place prior to July 1, 2010. Any changes to the marketing plan must be submitted to the Department for approval prior to use. The Department will review individual marketing materials and services as they are submitted (prior to their planned use), and approve, deny, or

ask for modifications within thirty (30) calendar days of the date of receipt by the Department.

- b. Submit all new and/or revised marketing and informational materials to the Department before their planned distribution. This includes materials in use prior to July 1, 2010. The Department will approve, deny, or ask for modifications to the materials within thirty (30) calendar days of the date of receipt by the Department.
- c. Submit a description of incentive award packages to the Department for approval prior to implementation. (Incentive award packages are not reimbursable by the Department.) This includes incentive award packages in use prior to July 1, 2010. The Provider is allowed to offer non-cash incentives to their enrolled members for the purposes of marketing, retaining the beneficiary within the service, and/or rewarding for compliance with stated goals and objectives within the beneficiary's Individual Service Plan. Non-cash incentives may include gift cards.

Providers will be subject to a fine or termination of the Provider's participation agreement if it conducts any marketing activity that is not approved in writing by the Department. The first violation will result in a \$1,000 fine, with the second violation resulting in a \$2,000 fine. The third violation will result in the termination of the provider's participation agreement with DMAS.

Existing marketing plans, marketing and informational materials, and/or incentive award packages must be submitted to DMAS for review by August 31, 2010.

If a new provider enrolls with Medicaid, the provider has 30 calendar days to submit the marketing and informational materials, and/or incentive award packages to DMAS for review. These materials shall not be used by the provider until receiving DMAS approval.

Once approved, marketing plans, marketing and informational materials, and/or incentive award packages must be reviewed and approved by DMAS whenever changes in content are made.

Providers may submit the marketing plan, marketing and informational materials, and/or incentive award packages for DMAS review via fax, e-mail or by mail.

Fax: (804) 612-0045

E-mail: cmhrsmarketing@dmas.virginia.gov

Physical address:

Office of Behavioral Health

Virginia Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

DMAS will review and approve, pend, or reject a marketing plan, marketing and informational material, and/or incentive award package within 30 calendar days of receipt of the request. If DMAS requests changes, the provider will have five (5) business days to respond to the request. DMAS will then review the proposed changes and will make a decision within fifteen (15) business days of receipt regarding the plan, materials, or incentive award package.

DMAS approval letters for marketing plans, marketing and informational materials, and/or incentive award packages must be maintained with the provider, and produced upon request by DMAS or its contractor if the provider is audited.