COMMONWEALTH of VIRGINIA

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OFFICE OF COMPREHENSIVE SERVICES
Administering the Comprehensive Services Act for At-Risk Youth and Families

ADMINISTRATIVE MEMO #13-08

TO: CPMT CHAIRS
CSA COORDINATORS

FROM: SUSAN CUMBIA CLARE, EXECUTIVE DIRECTOR
OFFICE OF COMPREHENSIVE SERVICES

DATE: AUGUST 14, 2013

SUBJECT: POLICY ADOPTION: USE OF STATE POOL FUNDS FOR COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES

The State Executive Council on July 31, 2013 adopted a policy regarding the use of state pool funds for three behavioral health services that are regulated by the Department of Medical Assistance Services. The three services included in the policy are Intensive InHome, Therapeutic Day Treatment, and Mental Health Support Services. Adoption of this policy ensures that these high-end, intensive services are appropriately matched to the clinical needs of children and youth and that the services, regardless of whether purchased with state pool funds or Medicaid funds, are delivered in accordance with consistent expectations for service components and provider qualifications.

Effective dates for the policy are as follows:

- Effective October 1, 2013, all newly developed individual family services plans must be compliant with the policy,
- Effective July 1, 2014, all existing (i.e., continuing) individual family services plans must be compliant with the policy,
- Effective July 1, 2014, localities will be subject to denial of funds policies for failure to comply with the policy.

The policy, implementation guidelines, and frequently asked questions (FAQ) are attached to this memorandum and have been posted to the CSA website. The policy has been incorporated into the CSA manual; the implementation guidelines and FAQ document have been posted to the Resource Library. Training regarding implementation of the policy will be scheduled in the near future.

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Questions about the policy may be directed to Carol Wilson, phone 804-662-9817, e-mail carol.wilson@csa.virginia.gov or Stacie Fisher, phone 804-662-9136, e-mail stacie.fisher@csa.virginia.gov.

cc: William A. Hazel, Secretary of Health and Human Resources
Members of the State Executive Council
Members of the State and Local Advisory Team

Policy Statement:
Use of State Pool Funds for Community-Based Behavioral Health Services
Adopted by the State Executive Council, July 31, 2013

The State Executive Council, pursuant to the authority granted it by COV §2.2-2648, shall provide for the establishment of interagency programmatic and fiscal policies which support the purposes of the Comprehensive Services Act (the "CSA"), and shall deny state funding to a locality which fails to provide services that comply with such interagency programmatic and fiscal policies, the CSA, any other state law or policy, or any federal law pertaining to the provision of services. For purposes of determining the use of Pool Funds for the purchase of community-based behavioral health services, the Office of Comprehensive Services shall apply the regulations established by the Department of Medical Assistance Services ("DMAS") regarding the appropriateness of such services. This policy, and the term "community-based behavioral health services" shall apply and refer to the following DMAS-regulated services: Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services. The CPMT may request an exception to this policy through the Office of Comprehensive Services when the CPMT believes there are exceptional circumstances that warrant exception to this policy and/or a Medicaid enrolled provider of a needed service is not available[3] for Medicaid-eligible children and youth. Such requests shall be made in writing and shall state the reason(s) and describe the circumstances supporting the CPMT's claim.

This policy shall be effective October 1, 2013 for new individual family services plans and shall be effective July 1, 2014 for all individual family services plans. Localities shall be subject to denial of funds policies for failing to comply with this policy beginning July 1, 2014. This policy shall revoke any previous guidance or statement of policy issued by the Office of Comprehensive Services or the State Executive Council regarding the use of CSA state Pool Funds to pay for these community-based behavioral health services, including, but not limited to such guidance issued July 19, 2011 by the Office of Comprehensive Services.

For Medicaid eligible children and youth: It is the intent of federal and state agencies governing the use of Medicaid funds to provide a full array of behavioral health services to meet 100% of the behavioral health needs of Medicaid-eligible clients. Thus, state Pool Funds shall not be used to purchase community-based behavioral health services for a Medicaid-eligible client. Children and youth in crisis[1] shall be referred to emergency services.[2] It is not the intent of this policy to prevent the use of Pool Funds to purchase non-behavioral health services necessary to meet the social, educational, or safety needs of Medicaid eligible children, youth and families.

For children and youth not eligible for Medicaid: It is the intent of the State Executive Council to ensure access to appropriate community-based behavioral health services for all children and youth served under the Comprehensive Services Act and to ensure the delivery of community-based behavioral health services to all children and youth regardless of whether services are funded by Medicaid or Pool Funds. For children and youth for whom community-based behavioral health services will be purchased with Pool Funds, the FAPT shall maintain documentation that the child or youth meets the criteria established by DMAS regulations for the specific community-based behavioral health service to be provided. This documentation shall include the signature and written approval of a licensed mental health professional. The licensed mental health professional shall state his/her credentials on such signed written approval and shall not be a supervisor of or the provider of the service for which approval is given. State Pool Funds may be used to purchase an independent clinical assessment conducted in accordance with DMAS requirements for such assessment.

[1] "crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened emotional, mental, physical, or behavioral distress; or any situation or

circumstance in which the individual perceives or experiences a sudden loss of his ability to use effective problem-solving and coping skills.

[2] "emergency services" means unscheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, detention, and preadmission screening activities associated with the judicial process. "Emergency services" does not include ongoing treatment services such as "community-based behavioral health services."

[3]"unavailable" means: a) there is not a Medicaid-eligible provider of the needed service within a reasonable geographic distance (e.g., up to 30 miles in urban areas or up to 60 miles in rural areas); or b) there is a waiting list that prevents the delivery of services within a reasonable time frame.

Use of State Pool Funds for Community-Based Behavioral Health Services
Guidelines for Implementation of Policy
Approved by the State Executive Council, July 31, 2013

Authority:

COV § 2.2-2648. State Executive Council for Comprehensive Services for At-Risk Youth and Families; membership; meetings; powers and duties.

D. The Council shall have the following powers and duties:

12. Oversee the development and implementation of uniform guidelines to include initial intake and screening assessment, development and implementation of a plan of care, service monitoring and periodic follow-up, and the formal review of the status of the youth and the family;

20. Deny state funding to a locality, in accordance with subdivision 19, where the CPMT fails to provide services that comply with the Comprehensive Services Act (§ 2.2-5200 et seq.), any other state law or policy, or any federal law pertaining to the provision of any service funded in accordance with § 2.2-5211;

Appropriation Act, Item 283 (D)

D. Community Policy and Management Teams shall use Medicaid-funded services whenever they are available for the appropriate treatment of children and youth receiving services under the Comprehensive Services Act for At-Risk Children and Youth. Effective July 1, 2009, pool funds shall not be spent for any service that can be funded through Medicaid for Medicaid-eligible children and youth except when Medicaid-funded services are unavailable or inappropriate for meeting the needs of a child.

Purpose:

The purposes of this policy are to:

1) Assure that all youth are matched with clinically appropriate services regardless of the funding source.

2) Assure use of consistent service definitions and standards for service delivery for all youth.

3) Assure maximum utilization of federal resources whenever appropriate to enable the most efficient use of state and local funds.

4) Decrease reliance on high-end, intensive, and costly services for children and youth who can benefit from non-clinical services, natural and community supports, and services to support basic child welfare needs, i.e., to ensure that children and youth receive the right services, in the right setting, and at the most efficient cost.

Implementation:

I. This policy applies to the use of Pool Funds for community-based behavioral health services regulated by the Department of Medical Assistance Services. This policy and these guidelines apply to the following services: Intensive In-Home, Mental Health Support Services, and Therapeutic Day Treatment.

II. Medicaid-eligible children and youth.

The policy states, “State Pool funds shall not be used to purchase community-based behavioral health services for a Medicaid-eligible client.” The policy will be implemented in accordance with language of the Appropriation Act which recognizes two circumstances under which the use of Medicaid funds may not be possible or appropriate.

A. Medicaid services are unavailable.

1. The policy defines "unavailable" to mean:

    a) there is not a Medicaid-eligible provider of the needed service within a reasonable geographic distance (e.g., up to 30 miles in urban areas or up to 60 miles in rural areas); or

    b) there is a waiting list that prevents the delivery of services within a reasonable time frame.

2. The policy allows the community policy and management team (CPMT) to request an exception to the policy through the Office of Comprehensive Services when a Medicaid-enrolled provider is not available.

    a) A request for an exception to the policy must be submitted to the Office of Comprehensive Services by the CPMT/authorized representative of the CPMT in writing prior to the initiation of any of the services covered by this policy (i.e., this policy does not restrict the initiation of emergency services), and must include the following:

        i. documentation of consult with DMAS or the DMAS behavioral health service administrator (BHSA) that a Medicaid-eligible provider is not available (DMAS/BHSA shall respond to inquiry within one workday),

        ii. documentation, with supporting evidence, as to why the locality has determined a Medicaid-eligible provider is unavailable,

        iii. the name and contact information for a locality representative who can provide additional information about the request to OCS as needed, and

        iv. the name and contact information for the CPMT representative who is authorized by the CPMT to request the policy exception on behalf of the CPMT.

    b) The Office of Comprehensive Services will:

        i. provide an on-line template for submission of exception requests,

        ii. review the request and all documentation submitted,

        iii. seek additional information from the named contact person (per item 2(a)(iii) above), as needed,

        iv. by the close of business no more than 5 full working days following receipt of the exception request, provided that the named contact person (per item 2(a)(iii) above) is available for consultation if needed, provide written determination regarding approval/denial of the request to the named representative/designee of the CPMT (per item 2(a)(iv) above) including written justification for the approval or denial of the request.

B. Medicaid funded services are inappropriate for meeting the needs of the child.

For purposes of implementing this policy, the term "inappropriate for meeting the needs of a child" means: a community-based behavioral health Medicaid funded service (i.e., Intensive In-Home, Mental Health Support Services, Therapeutic Day Treatment) is not appropriate to meet the presenting needs, e.g., per VICAP assessment and/or BHSA review; or the needs are related to family dysfunction, child or public safety, or special education.

The policy does not prohibit the locality from providing services that are appropriate to meet the presenting needs of the child. Such services would be services other than Intensive In-Home, Mental Health Support Services, or Therapeutic Day Treatment.

III. Children and youth not eligible for Medicaid

The FAPT shall maintain documentation that the child or youth meets the criteria established by DMAS regulations for the specific community-based behavioral health service to be provided.

A. As of June 2013 the governing DMAS regulations for the community-based behavioral health services covered by this policy are located in the following sections of Virginia Administrative Code (Emergency Regulations, adopted 7/18/2010):

1. Intensive In-Home:

   12VAC30-50-130(B)(5)(a) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reh+12VAC30-50-130+500625

   12VAC30-60-61(B) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-60-61

2. Mental Health Support Services:

   12VAC30-50-226(B)(6) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-50-226

   12VAC30-60-143(H) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-60-143

3. Therapeutic Day Treatment:

   12VAC50-150-130(B)(5) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-50-130

   12VAC30-60-61(C) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-60-61

B. Documentation that a child meets service criteria shall include the signature and written approval of a licensed mental health professional.

1. The policy allows flexibility in how the locality obtains the signature and written approval of the licensed mental health professional. Possible processes include:

   a. A licensed mental health professional (LMHP) is a member of the FAPT/MDT developing the Individual Family Services Plan (IFSP) and indicates approval of the recommended services by his/her signature on the IFSP.

   b. The LMHP reviews FAPT/MDT deliberations, recommendations, and the IFSP and indicates approval of the recommended services by his/her signature on the IFSP.

   c. The FAPT refers the child/youth to the Community Services Board for an assessment in accordance with the Virginia Independent Clinical Assessment Program (VICAP). State Pool Funds may be utilized to purchase the VICAP assessment.

2. The licensed mental health professional shall state his/her credentials on such signed approval.

3. The approving licensed mental health professional shall not be a supervisor of or the provider of the service for which approval is given.

IV. Exceptional circumstances

In the event a CPMT believes there are exceptional circumstances that warrant exception to this policy for a child/youth, the CPMT chair or authorized representative of the CPMT shall consult with the OCS Executive Director/designee. The OCS Executive Director/designee will determine documentation needed to assess the

circumstances and may authorize an exception to the policy. The determination of the Executive Director/designee shall be provided to the CPMT Chair in writing.

V. Change in DMAS regulations

1. Upon receipt of notice that new regulations are proposed OCS shall provide such notice to the State Executive Council and to CSA stakeholders. CSA stakeholders will be provided information to allow them to participate in the public comment process associated with the promulgation of new regulations.

2. When new DMAS regulations regarding the services covered by this policy are promulgated, the new regulations shall be utilized for purposes of determining the use of Pool Funds in accordance with this policy unless and until such time as the State Executive Council amends this policy. The SEC will review newly promulgated DMAS regulations regarding the services covered by this policy.

VI. Monitoring exceptions to the policy

The Office of Comprehensive Services will monitor CPMT requests for exceptions to the policy and provide summary reports to the Executive Committee of the State Executive Council.

Office of Comprehensive Services
Empowering communities to serve youth

Use of State Pool Funds for Community-Based Behavioral Health Services Frequently Asked Questions

1. What services are affected by this policy?

The policy adopted by the State Executive Council on July 31, 2013 applies to three community-based behavioral services that are regulated by the Department of Medical Assistance Services (DMAS) and commonly purchased with state pool funds. The services are: Intensive InHome, Therapeutic Day Treatment, and Mental Health Support Services.

2. Does this policy limit the decision-making authority of the local FAPT, i.e., erode local control over the CSA program?

Implementation of the CSA is a shared responsibility between the state and local governments. Both have specific statutory responsibilities for assuring services to at-risk youth and families. The Act provides flexibility to local governments by granting them authority to develop policies and procedures that will enable the community to meet the unique needs of its children, youth and families. Those policies and procedures, however, must comply with the requirements of the Act and policies established by the State Executive Council which holds statutory responsibility for governance of the program.

3. Why are DMAS regulations being applied to CSA?

The stated mission of the Comprehensive Services Act is to "create a collaborative system of services and funding…" The CSA was enacted to bring agencies together to deliver services to children, youth and families for the purpose of eliminating silos and reducing disparities in access to funding and services across the Commonwealth. This policy supports the mission of the CSA by ensuring consistency in how children access Intensive InHome, Therapeutic Day Treatment, and Mental Health Support Services and ensuring consistency in the services that are delivered to them – regardless of the funding that is used to purchase those services.

4. Are there other agency regulations that apply to CSA in the same way?

Yes. The application of DMAS regulations regarding these community-based behavioral health services parallels the application of laws and regulations that govern foster care services (e.g., Title IV-E of the Social Security Act); laws and regulations that govern services to students with disabilities (e.g., Individuals with Disabilities Education Act, "IDEA," and "Regulations Governing Special Education Programs for Children with Disabilities in Virginia"); and regulations governing licensure of facilities and services (e.g., licensing regulations of the Department of Behavioral Health Services, Department of Social Services, and Department of Education). Appropriate use of state pool funds requires that communities comply with "any other state law or policy, or any federal law pertaining to the provision of any service…"

5. What impact will this policy have on services to children, youth and families?

This policy supports Virginia's commitment to a comprehensive system of care, i.e., a collaborative system of services and funding. Through assurance that appropriate assessments are utilized to match services to the specific needs of children/youth and through assurance that services are clearly and consistently defined, the policy will improve the quality of services purchased through CSA pool funds and contribute to attainment of better outcomes for Virginia's children, youth and families. Better services and better outcomes will result in more effective use of financial resources and maximum availability of resources for those in need.

6. Does this policy require a VICAP assessment in order to access Intensive In-Home, Therapeutic Day Treatment, and Mental Health Support Services?

No. Because the services that are addressed by this policy are services designed to meet mental/behavioral health needs, the policy requires that a licensed mental health professional indicate that the services are in fact appropriate to meet the identified mental/behavioral health needs of the child or youth. Having a VICAP assessment completed is one means by which the locality may document the assessment and approval of a licensed mental health professional. The locality may also, however, document the assessment and approval of a licensed mental health professional through his/her signature on the individual family services plan. The licensed mental health professional may be a member of the FAPT or may review the FAPT assessment and the service plan subsequent to the FAPT meeting. The licensed mental health professional could be a member of the CPMT which approves funding for services recommended by the FAPT in the individual family services plan.

7. Will the VICAP be required for all CSA services in the future?

No. The VICAP was designed for the very specific purpose of assuring that community-based behavioral services are appropriate to meet the needs of a child or youth. CSA funding is utilized to purchase a broad array of services, many of which are not behavioral health services. It would not be appropriate to require a clinical assessment, i.e., VICAP, for the broad array of services funded under the CSA.

8. Does the policy require a licensed mental health professional (LMHP) to be on the FAPT?

No. Having an LMHP on the FAPT is only one means by which the FAPT may satisfy the requirement of this policy to have an LMHP certify the appropriateness of the services to meet a child/youth's needs. The LMHP may review the FAPT assessment and individual family services plan subsequent to the meeting. Additionally, the FAPT may refer children/youth to the community services board for completion of a VICAP assessment.

9. Will the requirement to have a licensed mental health professional approve the need for services increase costs to the locality?

Not necessarily. The locality has flexibility in how it meets this requirement. While a locality may not have a licensed mental health professional readily available to serve on its FAPT, its CPMT, or to review the FAPT assessment and individual family services plan subsequent to its meeting, all communities have access to the VICAP assessment process through a community services board. The locality does share in the cost of the VICAP assessment, and thus there is increased cost for such assessment. In the longer-term, however, research shows that the use of appropriate assessment to properly match services to the specific needs of children and youth reduces use of unnecessary services and multiple services, and produces better outcomes for children, youth and families. The initial investment in appropriate assessment is fully anticipated to increase the effective and efficient utilization of financial resources, i.e., to reduce the overall cost of services.

10. If a locality does not have a licensed mental health professional (LMHP) available to serve on the FAPT, how can it meet the requirement that an LMHP must certify the appropriateness of services?

Each community has the flexibility to determine the most effective means by which to meet the policy requirement that a LMHP assess and approve the services addressed by this policy. The LMHP may review the FAPT assessment and individual family services plan subsequent to the FAPT meeting or the child/youth may be referred to the local community services board for a VICAP assessment.

11. If the licensed mental health professional (LMHP) who serves on FAPT and/or reviews the IFSP works for the local community services board (CSB), does that mean the CSB cannot provide services to the child/youth identified for services?

No. The provision requiring that the LMHP not be the direct service provider or supervise the direct service provider assures protection against conflict of interest. As long as the LMHP is not the same person who will be serving the child/youth or will not be the direct supervisor of the person serving the child/youth, there would not be a conflict of interest. The LMHP may be employed by the same agency of the individual to serve the child/youth as long as he/she will not be directly providing or supervising the services to the child/youth.

12. Does the licensed mental health professional (LMHP) have to conduct a formal assessment equivalent to the assessment completed for the VICAP?

The policy recognizes that a primary function of the FAPT is to assess the strengths and needs of each child/youth. The FAPT assesses the strengths and needs through review of the CANS, information provided by the child/youth and family, information provided by the agencies and entities working with the child/youth and family, and other sources of information available to the team. Documentation of the FAPT assessment, with evidence of the LMHP review and support of the services recommended, is sufficient to meet the documentation requirements of assessment required by the policy.

13. Must a child/youth have a mental health diagnosis (e.g., DSM diagnosis) in order to receive Intensive InHome, Therapeutic Day Treatment, or Mental Health Support Services?

Yes. Because the services addressed in this policy are mental/behavioral health services, access to the services does require meeting the criteria of medical necessity which are established in DMAS regulations. Preliminary diagnoses and deferred diagnoses may be provided as evidence of medical necessity.

14. What documentation should the FAPT maintain to demonstrate that a child/youth meets the service criteria for each of the services?

It is recommended that the locality document the basis for its determination of medical necessity in FAPT minutes or in the IFSP and include supporting information in the case record.

15. What happens to a child/youth and family when the child/youth does not meet the criteria for one of these services, but the FAPT believes services are needed?

This policy does not prevent the provision of appropriate services to children, youth and families. When a child/youth's needs do not meet the medical necessity criteria established by DMAS regulations, the FAPT/CPMT is not restricted in the provision of alternative services, i.e., services other than Intensive InHome, Therapeutic Day Treatment, or Mental Health Support Services. In addition, the policy allows the CPMT to apply for an exception to the policy when it believes there are exceptional circumstances that apply to an individual child/youth which warrant an exception to the policy.

16. Will this policy prevent children/youth who have suffered trauma but don't have a mental health diagnosis from receiving services?

While it is likely that most children/youth who exhibit symptoms resulting from trauma will qualify for a mental health diagnosis, e.g., adjustment disorder, a preliminary diagnosis or deferred diagnosis may be provided as evidence of medical necessity.

17. What happens when a child/youth is in crisis and services are needed immediately to protect his/her safety and/or the safety of others?

This policy does not prohibit the provision of emergency services that are necessary to address crisis circumstances. The services addressed by this policy are not emergency services. The policy defines the terms "crisis" and "emergency services" to ensure clarity that there is nothing in the policy that interferes with a locality's ability to address crisis circumstances and/or to utilize emergency services.

18. What happens when a Medicaid-eligible child/youth meets the criteria for services but there is not a Medicaid-eligible provider in our area to provide the service?

DMAS has contracted with Magellan to serve as the administrator of behavioral health services for Medicaid-eligible clients. Magellan is charged with responsibility to build a network of service providers to ensure maximum access to services across the Commonwealth. Magellan will provide resources to assist localities in the identification of service providers (e.g., web-based search capability and phone consultation). If a service provider cannot be located, the policy allows for the CPMT to request an exception to the

policy through the Office of Comprehensive Services. Approval of an exception will enable the locality to utilize state pool funds to purchase services from a non-Medicaid eligible provider when necessary.

19. Does the FAPT/CPMT have responsibility to hold service providers accountable for implementing the DMAS regulations regarding these services?

Yes. In addition to identifying the medical necessity criteria for services, DMAS regulations identify provider qualifications and specific service requirements. CSA statutes require that each CPMT have policies and procedures to conduct utilization review (UR) of the services purchased through CSA state pool funds. Understanding service components and assuring that they are appropriately delivered is a function of utilization review as well as an expectation for general contract monitoring and accountability for purchased services. Through its UR activities, the locality is responsible to assure that providers are delivering the contracted services to youth. Because the services covered by the policy are licensed through the Department of Behavioral Health and Developmental Services (DBHDS), providers are also subject to oversight by DBHDS for compliance with licensing requirements.

20. How does a locality know which DMAS regulations are relevant to this policy?

Implementation guidelines to accompany the policy were approved by the State Executive Council. These guidelines identify the specific sections of DMAS regulations that pertain to Intensive InHome, Therapeutic Day Treatment, and Mental Health Support Services. Training will be provided to local communities on the policy, the guidelines, and the relevant regulations and resources will be posted to the CSA website Resource Library.

21. When does this policy go into effect?

Compliance with the policy will be required for all new individual family services plans developed on or after October 1, 2013. Compliance with the policy will be required for all individual family services plans by July 1, 2014. Localities will be subject to denial of funds for failure to comply with the policy beginning July 1, 2014.