

ORANGE COUNTY, VIRGINIA  
OFFICE ON YOUTH

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**To:** Orange County Board of Supervisors

**From:** Alisha Vines, Office on Youth Director *AV*

**Through:** Julie Jordan, County Administrator *JJ*

**Date:** August 16, 2011

**Subject:** CSA Monthly Report

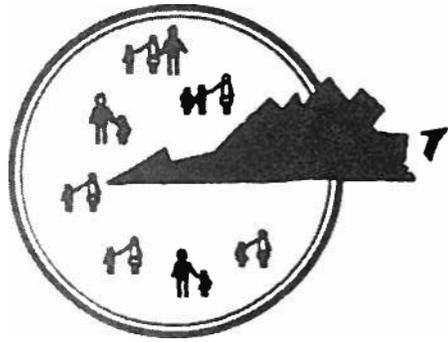
Please find attached the July Report for CSA. This is the end of the year for Fiscal Year 11. Letitia is still waiting for several invoices to be turned in for services but we are expecting to come in under the appropriated amount. It has been a long, hard year, but the FAPT and CPMT teams have worked very hard with Letitia in keeping costs down as much as possible and as we look forward at Fiscal Year 12, we will remain diligent in these efforts.

As I stated in my last Office on Youth update, CSA is going forward with the changes we presented to you in the May meeting regarding denial of funding. Please see the enclosed documentation for more information. I have also included information on the Medicaid changes. Please feel free to read over those documents and reach out to Letitia or myself with any questions you may have. We may not know the answers immediately but we will work very hard to find out.

We will keep the Board informed of all of these current and any future issues that may arise. Please review the attached report and let myself or Letitia know if you have any questions.

**Cc:** Letitia Douthit  
File

8/16/11



COMPREHENSIVE SERVICES FOR AT-RISK YOUTH AND FAMILIES  
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ORANGE COUNTY FAMILY PLANNING AND ASSESSMENT TEAM  
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## Comprehensive Services Act Program Information

### FY 11 Wrap up:

FY 11 County Budget: \$1,320,000      Adjusted: \$2,302,987.00

Current FY 11 YTD Expenses as of 8/9/11 for remaining Fiscal year:

Apr. Amount	YTD Exp	Balance
2,302,987.00	2,241,295.96	61,691.04

CSA will be under budget as of the end of the fiscal year, there are three invoices that are outstanding and two minor invoice discrepancies that I am working to clear up totaling approximately \$11,691. In addition, CSA will be receiving approximately \$24,000 in refunds due to Medicaid funding payments that had been paid by CSA.

As of June 30<sup>th</sup>, we have served 88 Youths/Families compared to 82 in FY 10

Total Foster Care: 40\*\*

- \*\* 13 are court placed – to include charges of assault & battery, sexual offenses, breaking & entering, destruction of property, etc.
- Residential Placements YTD: 17      as of 6/20/11: 6

Foster Care Prevention: 49

Special Education Private Day placement (IEP): 2

Costs of Services (average):

- Intensive Care Coordination: \$750/m
- Parent Mentor Services: \$30/hr
- Mentoring: \$42/hr
- KEYS Program (Counseling Interventions): \$52/hr
- In Home counseling: \$62/hr
- Therapeutic Day treatment in schools/community: \$115/hr
- Therapeutic Behavioral Aide schools/community \$38/hr

Going Forward into FY 12, I have only just started receiving invoices and will have some early projections in the September report. Please see attachments on issues that CSA will be facing in this new Fiscal Year. First, the New SEC Denial Policy is the same proposed policy change that you spoke out against and secondly, is a Medicaid Memo and CSA Guidance document on the addition of an Independent CSB assessment to access Medicaid funding and services. It is too early to tell, exactly how these changes will affect Orange County CSA, but we will keep you informed.

Thank-you

## **Guidance for Community Policy and Management Teams (CPMTs) and Family Assessment and Planning Teams (FAPTs) regarding Medicaid Independent Clinical Assessment and Children or Youth served by the Comprehensive Services Act (CSA)**

### **Medicaid Requirement for Independent Clinical Assessment for Children's Community Mental Health Rehabilitative Services**

As many of you have been made aware, effective July 18, 2011, the Department of Medical Assistance Services (DMAS) requires an independent clinical assessment for all new Medicaid and FAMIS children's community mental health rehabilitative services (CMHRS). DMAS has contracted with local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) to conduct the required assessment. The services included are:

- Intensive In-Home (IIH),
- Therapeutic Day Treatment (TDT), and
- Mental Health Support Services (MHSS)

As of September 1, 2011, an independent clinical assessment will be required for those individuals currently receiving services and whose service re-authorization is due for dates of service on or after September 1, 2011.

In November, Level A and Level B residential services will also require these assessments prior to service approval from Medicaid.

The details of the process for the Medicaid clinical independent assessment through the CSB or BHA can be found in the Medicaid provider memo dated June 16, 2011. A direct link is not possible as DMAS is revising the website. To see the memo, go to [www.csa.virginia.gov](http://www.csa.virginia.gov) and click on "Medicaid Provider Memos", select the year 2011, and a listing of current memos will appear. The memo will also be distributed with this guidance document. **Please read the Medicaid memo carefully as it will explain the process of obtaining the independent clinical assessment as well as the provider process of obtaining service authorization.** Questions about the Medicaid independent clinical assessment process, including appeals and Medicaid provider responsibilities and requests for service authorization, should be addressed to DMAS.

## **Coordination of the Medicaid Independent Clinical Assessment conducted by the Community Services Boards or Behavioral Health Authority for Children and Youth served by the Comprehensive Services Act**

This guidance is being provided by the Office of Comprehensive Services (OCS) to address concerns expressed by local governments regarding the new Medicaid requirement, such as:

- Will CSA be responsible for the potential “overflow” of children and youth who currently would not be involved with CSA, but whose parents seek services from FAPTs when the Medicaid independent clinical assessment determines the child does not meet the criteria for Medicaid eligibility for services?
- How does the determination of the Medicaid independent clinical assessment affect the use of CSA funds for the child and family? For example, what happens if the independent clinical assessment determines that the child does not meet the Medicaid level of need for the service requested, but the FAPT believes that the service is necessary to prevent the placement of the child into foster care? Will OCS deny the state share of pool funding because the Medicaid assessment did not deem the service was necessary?
- What should FAPTs do if the determination reached by the Medicaid independent clinical assessment conflicts with the CANS ratings or recommendations?
- Should CPMTs develop local policy and procedure regarding the new Medicaid requirement?
- Aren't costs for these families just being shifted from one funding source to another? Will anyone be monitoring to see if there are any actual cost savings to the state as a whole?

### **Eligibility for CSA**

All children and youth must meet the CSA eligibility criteria before pool funds can be accessed to pay for services. Most of the children and youth in the Commonwealth receiving Medicaid and or FAMIS funding for healthcare are not eligible for mandated or non-mandated CSA. If a parent seeks CSA funding for a service from FAPT because Medicaid has been denied, the child's eligibility for CSA must first be determined. See Section 4.2 of the CSA Manual. ([CSA Manual Eligibility Criteria](#))

### **Service Planning and Decision-Making Process**

For those youth who are eligible for CSA-funded services, the service planning and decision-making process is still the same as what currently exists. The FAPT is encouraged to review the Medicaid independent clinical assessment in the course of their treatment planning. However, if the FAPT does their assessment and planning, including the CANS, and determines that a service or services are necessary and appropriate, then regardless of the lack of recommendation of the Medicaid independent clinical assessment (and there is no other funding source) then CSA funds may be used. This is no different from a current situation where Medicaid or KePRO denies payment for a

service that the FAPT believes to be necessary. It is entirely possible that a child's Medicaid assessment might not meet the clinical medical level of need for a service, but the FAPT must consider many other factors in making such a decision, such as prior involvement with Child Protective Services, family dynamics of abuse, neglect or domestic violence, a family's support system, and numerous other variables.

As with all CSA services, the local Family Assessment and Planning Team is responsible for making service decisions and it is the role of the Community Policy and Management Team to approve the funding for these services. OCS cannot deny the state share of CSA funding for a service denied by Medicaid, if the FAPT, in accordance with federal and state law, CSA policies, and the policies established by their CPMT, determines that the child and family are in need of the services.

### **Medicaid Independent Clinical Assessment and the CSA Child and Adolescent Needs and Strengths (CANS) Assessment**

The FAPT may request, and is encouraged to review the results of the Medicaid clinical independent assessment to inform their decision-making with the approval and signed release of information from the family. If the recommendation of the independent clinical assessment conflicts with CANS ratings on key items or the CANVaS system recommendation which is currently being piloted, it may be important to note what the discrepancies are and determine the cause. The FAPT may wish to discuss the discrepancies with the CSB representative on the FAPT. However, the CANS and the Medicaid independent clinical assessment conducted by the CSB/BHA are very different types of instruments and it is quite possible that results may vary.

### **CPMT Policy and Procedures**

The Code of Virginia (§2.2-5206 (5)) requires that CPMTs "Establish policies governing referrals and reviews of children and families to the family assessment and planning teams or a collaborative, multidisciplinary team process approved by the Council and a process to review the teams' recommendations and requests for funding;..." As with any change or new process, local policies and procedures should be revised to include how FAPTs will handle these referrals. One topic that could be addressed is how the FAPT will deal with referrals from families who seek CSA funding when the Medicaid independent clinical assessment does not recommend the service.

### **Potential Shifting of Costs**

If there does appear to be an increase in the use of CSA funds to cover services previously funded through Medicaid, it would be very helpful for FAPTs to document that increase. If such a trend is noted, the CPMT should share that data regarding the transfer of costs with DMAS and OCS so it may be used in future policy and legislative revisions.

## **Possible Case Examples**

The following examples are provided to reflect possible ways the new Medicaid requirement will be coordinated with the work of the FAPT. They do not and cannot reflect the myriad of situations that will present to the FAPT, but are intended to provide some basic guidance. The examples do not explain the Medicaid provider process in detail; for that information, please refer to the Medicaid Memo dated June 16, 2011.

### *Example #1*

Sharri is in family foster care and has been diagnosed with Schizophrenia. Sharri is 17 and as part of her transition plan, mental health supports are suggested to help her learn life skills in the community since she has difficulty recognizing personal dangers. Sharri's foster family takes Sharri to the CSB for her Medicaid independent clinical assessment and the assessment does not show that Sharri meets clinical criteria for Mental Health supports. Since the Medicaid independent clinical assessment did not recommend mental health support services, no provider was identified at that time. The FAPT and foster family still believe that in order to increase Sharri's exposure to the community and help her recognize danger that she is in need of these services. The Individual and Family Services Plan (IFSP) is written to include mental health supports and a private provider is identified.

If a Medicaid provider is selected, the provider can submit a request to KePRO for service authorization (with appropriate documentation-see Medicaid Memo dated 6/16/2011) even though the Medicaid independent clinical assessment did not recommend the service. However, unless there is substantial reason to believe the independent clinical assessment was incorrect or significant changes have occurred, the provider is not required to submit the service authorization request. If the provider does not submit a service authorization request in this instance, and there is no other funding source, CSA funds are used. If the provider submits the service authorization request and KePRO denies the request, and there is no other funding source, CSA funds should be used.

If a non-Medicaid provider is selected, and there is no other funding available, CSA funds are used to cover the cost of services.

### *Example #2*

Estephon is a fourteen year old whose family has been given a brochure regarding intensive in-home services and since Estephon has been talking back to his mother, not doing his chores, and his grades are slipping, his family approaches the provider for these services using their FAMIS plan. The provider helps them set up their independent clinical assessment at the local CSB and the independent clinical assessment does not recommend intensive in-home services since there have been no other interventions tried. Estephon's family is told by the provider that they can use CSA funds for this service and to try to get a FAPT meeting. The parents contact the local CSA office and it is

explained to them that Estephon does not meet criteria for eligibility for CSA funding; however there are some other non-CSA services that they may want to try such as individual or family therapy that will meet the family's needs.

### *Example #3*

Joshua, who is seven years old, has been determined eligible for mandated CSA funding through foster care prevention and after completing a CANS and a FAPT meeting with the family, it has been decided that intensive in-home services are necessary to prevent the removal of Joshua from the home. Since Joshua has Medicaid, the FAPT explains to the family that the local CSB will conduct a Medicaid independent clinical assessment to determine if Medicaid will cover the cost of this service.

The independent clinical assessment indicates the need for intensive in-home services and a provider is selected. The FAPT believes that these services are necessary to prevent Joshua's removal from the home. If the selected provider is a Medicaid provider, then that provider submits a request for service authorization to KePRO (along with required documentation-see Medicaid Memo dated 6/16/2011) for intensive in-home services. If services are needed immediately, and there is no other funding source, CSA funding should be used to cover the cost of these services while waiting for a decision from KePRO. If KePRO authorizes the services, Medicaid funding is used. If KePRO denies authorization of the services and the provider appeals, CSA funding (again, if there is no other funding source) should be used to cover the costs of the services while waiting the outcome of the appeal. If the appeal is denied, CSA funds are used. If the Medicaid appeal is successful and services are authorized, Medicaid funds are used.

If the selected provider is not a Medicaid provider, CSA funds are used to pay for the services if the FAPT deems the services are necessary to prevent removal, there are no other funds available, and the services are included on the IFSP.

### **Conclusion**

Use of Medicaid-funded services is required whenever they are available and appropriate for the treatment of children and youth receiving services under the Comprehensive Services Act. However, it is important to understand that the purpose of CSA funding is to meet the child and family's needs if the child is CSA-eligible and the FAPT has determined the service is necessary and included it on the IFSP. Delays in accessing Medicaid funding must not prevent service provision for children who are mandated to receive services under the Comprehensive Services Act.

**Draft of Policies Regarding Denial of Funding to Local Governments (Community Policy and Management Teams) not in Compliance with Provisions of the Comprehensive Services Act for At-Risk Youth and Families (CSA)**

House Bill 1679 (Chapter 397) and Senate Bill 1171 (Chapter 413) enacted by the 2011 Virginia General Assembly revised the Code of Virginia § 2.2-2648 to read:

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*; (new language in italics)

**I. Review of state law, policy or federal law that would require compliance by a locality for reimbursement of the cost of services provided**

A review of the role of entities involved in the provision of services through the Comprehensive Services Act is necessary to ensure understanding of what the Code of Virginia, federal law and other requirements must be met in order to access funds through the Comprehensive Services Act.

*General Statutory Requirements of CSA Entities*

**State Child-Serving Agencies** (*Virginia Departments of Social Services, Behavioral Health and Developmental Services, Juvenile Justice, Medical Assistance Services and Education*)

It is not the role of the Office of Comprehensive Services to develop, revise or oversee any of the policies of other state agencies. The Office of Comprehensive Services works with these agencies to align policy so it is consistent with the Comprehensive Services Act. It is important to note that these agencies serve multiple children and families that are not involved with services provided by the Comprehensive Services Act. Those policies that do intersect with the Office of Comprehensive Services will be attached to the CSA manual found at [www.csa.virginia.gov](http://www.csa.virginia.gov). These agencies are the Department of Social Services, the Department of Education, the Department of Juvenile Justice and the Department of Behavioral Health and Developmental Services.

**Office of Comprehensive Services**

The statutory responsibilities of the Office of Comprehensive Services are described primarily in COV §2.2-2649 and in the Appropriations Act (Item 274). These responsibilities include the development and recommendation to the SEC of programs and policies that promote the intent of the Comprehensive Services Act. The Office of

Comprehensive Services fiscal policies are found in the CSA Manual at [http://www.csa.virginia.gov/html/csamannual/CSA%20Policy%20Manual2011\\_020911update](http://www.csa.virginia.gov/html/csamannual/CSA%20Policy%20Manual2011_020911update) The Code of Virginia places the responsibility of developing and recommending policies to ensure compliance with CSA with the Office of Comprehensive Services.

### **Community Policy and Management Team (CPMT)**

The Community Policy and Management Team (CPMT) is responsible for management and oversight of the use of CSA pool funds. It has specific authority by Code for the provision of CSA services (COV § 2.2-5206 and Item 274 of the Appropriations Act). Membership of the CPMT is outlined in Code (§ 2.2-5205) and includes local leaders, such as the public agency directors, private providers and parents. Members are appointed to the CPMT by the local governing body. (§ 2.2-5204)

### **Providers of Services**

Community Policy and Management Teams and Family Assessment and Planning Teams (CPMT) each have a direct relationship with the service providers who work with children and families. The CPMT is responsible for service needs assessment and planning (§ 2.2-5206) and is the local fiscal authority which approves or denies funding for service expenditures. CPMTs are empowered by statute to enter into contracts for service provision. Family Assessment and Planning Team (FAPT) members work closely with providers regarding the development and provision of individualized services for children and their families (§ 2.2-5208).

The Office of Comprehensive Services strongly recommends that CPMTs enter into contractual relationships with providers in order to clearly delineate the expectations, responsibilities and obligations of each party. Contracts are a well-accepted means of negotiating expectations. A standard model contract is available on the CSA website for use by CPMTs. (<http://www.csa.virginia.gov/html/news/news061903stdct.cfm> )

### **The Office of Comprehensive Services Relationship with Local CPMT**

The Office of Comprehensive Services maintains a fiscal and program relationship with local governments, specifically the Community Policy and Management Team. As noted above, the CPMT has the responsibility and authority to contract with providers regarding the provision of services to community children and families. The Office of Comprehensive Services does not have a fiscal or contractual relationship with providers of services; rather, it is the role of the local CPMT to work directly with providers.

Local governments enter into agreements with providers for child-specific services. Providers are paid by local governments through the CPMT for these services. Local governments, in turn, through the CPMT, request a state match for partial reimbursement of the aggregate cost of the CSA funded services. There is no current mechanism for the Office of Comprehensive Services to know which providers may be affected by denial of funding to a locality. As the relationship exists between the Office of Comprehensive

Services and the locality, it is not appropriate for the Office of Comprehensive Services to notify providers if state match funds are being denied to a locality; it is the local government or CPMT's decision regarding such notification. The locality may elect to continue to work with that service provider, but utilize a different funding source, including local-only funds, to pay for those services.

All of the requirements specific to the Comprehensive Services Act are outlined in the Code of Virginia and the Appropriations Act (Item 274). The statutory requirements and authority of the State Executive Council (§ 2.2.-2648) the State and Local Advisory Team (§ 2.2-5202), the Office of Comprehensive Services (§ 2.2-2649), the local Community Policy and Management Team (§ 2.2-5206), and the local Family Assessment and Planning Team (§ 2.2-5208) are described. Additional requirements are found in the Comprehensive Services Act (§ 2.2-5200 et. seq.), the Appropriations Act and State Executive Council policy. **Violations of any state or federal law or policy may result in denial of funds.**

### **Comprehensive Services Act Manual**

The Comprehensive Services Act (CSA) Manual, found at [www.csa.virginia.gov](http://www.csa.virginia.gov) offers an organized look at the relevant statutes and policy decisions made by the SEC since the inception of CSA. *Only statutory requirements and SEC policy are in the manual proper.* Toolkits and Appendices provide additional information, including the policies and requirements provided by the agencies whose services the CSA must supply funding, as well as Guidelines and Frequently Asked Questions (FAQs). Denials of the CSA state match funding are based on a locality's failure to comply with, or violations of, statutory requirements and policy, whether they are specific to the CSA or are those promulgated by the participating agencies.

### **State Licensure for the Provision of State-funded Services**

Any service which requires licensure can only be rendered by a provider licensed to provide that service in Virginia. State law requiring licensure of providers may be found at § 37.2-405.

The following state agencies require licensure of specific services that are provided to children and families funded by the CSA. Each maintains a website listing of provider licensure and status of that licensure.

#### *Department of Behavioral Health and Developmental Services*

For a listing of providers licensed by the Virginia Department of Behavioral Health and Developmental Services, go to <http://www.dbhds.virginia.gov/LPSS/LPSS.aspx> Details such as the type of license, expiration date, licensure number and any stipulations are noted. More details regarding the DBHDS licensing process may be found at <http://www.dbhds.virginia.gov/OL-default.htm>

The Department of Behavioral Health and Developmental Services has a list of services that require a license by that agency. That list can be located at <http://www.dbhds.virginia.gov/OL-default.htm> and is included as Attachment A to this policy document.

*Virginia Department of Education*

Information regarding the licensure of special education providers may be found at [http://www.doe.virginia.gov/special\\_ed/day\\_residential\\_schools/index.shtml](http://www.doe.virginia.gov/special_ed/day_residential_schools/index.shtml). The Code of Virginia requires licensure for schools for students with disabilities issued by the Board of Education (§ 22.1-323). A listing of approved private day and residential facility school providers may be found at the same link noted above - [http://www.doe.virginia.gov/special\\_ed/day\\_residential\\_schools/index.shtml](http://www.doe.virginia.gov/special_ed/day_residential_schools/index.shtml)

*Department for Social Services*

A listing of the types of programs (child care, family homes, residential facilities, etc.) which are licensed by the Virginia Department for Social Services is found at [http://www.dss.virginia.gov/family/children\\_background.cgi](http://www.dss.virginia.gov/family/children_background.cgi). This listing includes links for each type which take the reader to information including, but not limited to, the applicable regulations and code references, current providers and the status of licensure of providers.

*Department of Juvenile Justice*

The ~~Board of Department of~~ Juvenile Justice does not “license” agencies or programs that may provide services to children and families that are funded by CSA. However, it does provide certification, a reasonable equivalent of licensure, to various locally-operated group homes that may potentially provide services funded by CSA. The specific regulatory authority under which the ~~Department Board~~ of Juvenile Justice certifies these programs is found in [Virginia Administrative Code 6VAC35-51](#) and [Virginia Administrative Code 6VAC35-140](#)

*Current Statutory Requirement for Other Agency Contact with OCS*

Agencies which provide licensure of services for children served through CSA must routinely contact the Office of Comprehensive Services to provide updated licensure status information which the Office of Comprehensive Services immediately passes on to localities via a state list serve.

Legislation enacted by the 2007 General Assembly requires specific actions if the licensure status of a residential facility is lowered to provisional because of multiple health and safety violations or human rights violations and children placed in that facility are receiving CSA-funded services. An assessment of the individual child receiving

CSA-funded services should be conducted to ascertain the continued safety and appropriateness of the placement for that child. No additional children may be placed using CSA funds in the facility until full licensure status is restored. (§ 2.2-5211.1) Because of this requirement, the Office of Comprehensive Services began notification via the CSA list serve to localities when the Office of Comprehensive Services is notified by DSS, DOE or DBHDS of licensure changes.

## **II. Responsibility of the locality and other state agencies for notifying the Office of Comprehensive Services when services are suspected or determined “non-compliant” by agencies other than the Office of Comprehensive Services**

Any state or local agency, or CPMT, that has cause to believe that the statutory requirements of CSA, including those relating to licensure, are not being met by a locality shall contact the Director of the Office of Comprehensive Services. State aAgencies are responsible for notifying the Office of Comprehensive Services when a provider loses a license, even if that provider is not currently billing for services. OCS will make reasonable efforts to notify localities.

Copies of local audits which include review of CSA funding must be provided to the Office of Comprehensive Services within three business days from presentation to the local governing body~~receipt by the locality~~. If the local audit determines that services provided which affect CSA, for example Title IV-E, were inappropriate, the locality must inform the Office of Comprehensive Services.

### *Contacting the Office of Comprehensive Services*

The Director of the Office of Comprehensive Services may be reached at:

1604 Santa Rosa Road,  
Suite 137  
Richmond, Virginia 23229

or by phone at (804) 662-9815. Information may also be faxed to (804) 662-9831 or by email at [csa.office@dss.virginia.gov](mailto:csa.office@dss.virginia.gov).

## **III. Notification to localities who are suspected or determined “non-compliant” by the Office of Comprehensive Services**

Steps A-F outline the procedure followed by Office of Comprehensive Services to investigate suspected or determined non-compliance by a locality.

- A. The Office of Comprehensive Services will investigate the complaint by reviewing available data, including but not limited to, documentation submitted by the complainant, CSA data set and fiscal pool fund reporting reimbursement,

local financial and program records, including CPMT and FAPT minutes, other information supplied by the locality and interviewing appropriate individuals, if necessary. The Office of Comprehensive Services may consult with the Office of the Attorney General and any other parties it deems appropriate.

- B. State and local agencies, including the one reporting the alleged inappropriate use of funds, shall supply any necessary and/or requested supporting documentation relevant to the allegation.
- C. If the Office of Comprehensive Services is unable to determine the validity of the report or determines there was no violation, the incident is closed with notification to the reporting state agency and the CPMT in question.
- D. If the Office of Comprehensive Services suspects non compliance but has not yet made a determination of such, the Office of Comprehensive Services ~~may~~ **shall** communicate with the Chief Administrative Officer of the locality and the CPMT Chair ~~CPMT chair~~ as appropriate to resolve the issue.
- E. If the Office of Comprehensive Services determines that a violation of state law or policy, or any federal law pertaining to the provision of any service funded in accordance with § 2.2-5211 has occurred, the Office of Comprehensive Services will notify the chief administrative officer of the local government and the CPMT chair within five business days. The Office of Comprehensive Services will request the locality immediately discontinue that practice and the locality should notify any affected providers. The Office of Comprehensive Services will also describe the actions it intends to take, if any. Such action may include but is not limited to, a corrective action plan developed in consultation with the locality and/or denial of state funding. Failure of the Office of Comprehensive Services to meet the timeline does not preclude the Office of Comprehensive Services from denying funds or recovering payments.
- F. The process described in the CSA Dispute Resolution Process (§2.2-2648 D 19) and the State Executive Council policy appeals process (CSA Manual, Section 3.4) will apply. The Dispute Resolution Process is outlined in the CSA Policy Manual at [http://www.csa.virginia.gov/html/csamanual/CSA%20Policy%20Manual2011\\_020911update.pdf](http://www.csa.virginia.gov/html/csamanual/CSA%20Policy%20Manual2011_020911update.pdf).

#### **IV. Responsibility of the agencies other than the Office of Comprehensive Services for supplying supportive documentation when they determined the services were non-compliant.**

If another state agency learns during the course of its work (routine reviews, audits, complaint investigations, etc.) of a violation of state law affecting the provision of

services under the Comprehensive Services Act, the agency shall contact the Office of Comprehensive Services using the methods noted in Section II and provide any supporting documentation.

Steps A-F noted above in Section III will be followed.

**V. Notification by the Office of Comprehensive Services to the locality whose services were determined “non-compliant” by agencies other than the Office of Comprehensive Services and therefore are not eligible for CSA funding.**

If another agency discovers or learns of what it believes to be a possible violation of the CSA, the responsible agency staff person should contact the Executive Director of the Office of Comprehensive Services (contact information in Section II) and explain what agency policy or federal or state law is involved, how the other agency believes the violation has occurred and the impact of, or relationship to, the CSA.

Steps A-F noted in Section III above will be followed.

**VI. Notification by the Office of Comprehensive Services to the locality whose services were determined “non-compliant” with the provisions of the Comprehensive Services Act and therefore is not eligible for CSA funding.**

Steps A-F noted in Section III above will be followed.

**VII. Notifying and seeking support from the agencies other than the Office of Comprehensive Services when the Office of Comprehensive Services has reason to believe the services were non-compliant with that other agency’s requirements.**

If the Office of Comprehensive Services becomes aware of a violation of another agency’s laws, policies or requirements that affects the provision of services funded by the Comprehensive Services Act, the Executive Director (or designee) will contact the appropriate staff person at the other agency. The Office of Comprehensive Services will provide any supporting documentation requested by the other agency.

**VIII. Determination of the “look-back” period on denial of funds.**

This policy takes effect July 1, 2011. Pursuant to § 2.2-2648, the Office of Comprehensive Services may deny funding to local governments not in compliance with the provisions of the Comprehensive Services Act and federal and state law.

The Office of Comprehensive Services may review payments and conduct audits for a period of time, three years before or after the date of the alleged noncompliance (not to exceed a total of three years), regardless of the date of discovery of the alleged noncompliance.

Should the Office of Comprehensive Services discover noncompliance, the Office of Comprehensive Services may request that the Auditor of Public Accounts (APA) determine whether to pursue an audit of a locality. This policy should not be construed to put any limitations on the APA or other parties that have responsibilities regarding the Commonwealth's or federal funds and their investigation of the use of those funds.

### **IX. Technical Assistance and Training**

The Office of Comprehensive Services, in collaboration with partner agencies, will provide additional technical assistance to local governments and CSA Coordinators in the development of each locality's CSA policies and procedures. The Office of Comprehensive Services, in collaboration with partner agencies, will provide training and technical assistance related to laws, regulations and policies that would be confronted by local systems. Those that are most common would include:

- Licensure laws promulgated by partner agencies
- Issues related to federal laws that supersede state law, such as IDEA or Fostering Connections
- CSA fiscal policies promulgated by the SEC
- Basic facts of the Comprehensive Services Act, such as the responsibilities of the CPMT for fiscal accountability
- Eligible populations to access CSA pool funds

This is not an exhaustive list and will be modified and updated as changes occur.

Currently the Office of Comprehensive Services does not publicly post information regarding alleged CPMT violations of the CSA requirements or denial of funding to a locality. This decision is made at the discretion of the local CPMT or local government who may choose whether or not to share this information. If CPMTs or local governments wish to share this information, the CPMT may post it on the "CSA Discussion List" (list serve) and request that the Office of Comprehensive Services post the information on the CSA website. If the disagreement is not resolved and an appeal is made to the SEC, the information regarding the denial and appeal will become public.

After July 1, 2011, the Office of Comprehensive Services will publish on the CSA website and post on the list serve a brief description of any violation which has resulted in the denial of funds to a locality. This information will be non-identifying. This information will be included in training and technical assistance activities conducted by the Office of Comprehensive Services.

Any local government official or member of the CPMT may sign up to receive e-mail notification via the CSA Discussion List of any changes that may affect reimbursement. Such changes are routinely communicated via the list serve and by posting on the CSA website. To register for the list serve, individuals should e-mail the CSA webmaster at [www.csa.virginia.gov](http://www.csa.virginia.gov).

To register for trainings or to receive technical assistance, individuals may contact the Office of Comprehensive Services.

## ATTACHMENT A

*Services requiring licensure (<http://www.dbhds.virginia.gov/OL-default.htm>) by the Virginia Department of Behavioral Health and Development Services*

### PART II.

#### LICENSING PROCESS.

##### **12 VAC 35-105-30. Licenses.**

A. Licenses are issued to providers who offer services to one or a combination of the following disability groups: persons with mental illness, persons with mental retardation, persons with substance addiction or abuse problems, or persons with related conditions served under the IFDDS Waiver or persons with brain injury served under the Brain Injury Waiver or in a residential service.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Case management;
2. Clubhouse;
3. Community gero-psychiatric residential;
4. Community intermediate care facility-MR;
5. Crisis stabilization (residential and nonresidential);
6. Day support;
7. Day treatment;
8. Group home residential;
9. Inpatient psychiatric;
10. Intensive Community Treatment (ICT);
11. Intensive in-home;
12. Intensive outpatient;
13. Medical detoxification;
14. Mental health community support;

Draft June 16, 2011

9



Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

<http://www.dmas.state.va.us>

# MEDICAID MEMO

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

**FROM:** Gregg A. Pane, MD, MPA, Director  
Department of Medical Assistance Services (DMAS)

**MEMO:** Special  
**DATE:** 6/16/2011

**SUBJECT:** New Service Authorization Requirement for an Independent Clinical Assessment for Medicaid and FAMIS Children's Community Mental Health Rehabilitative Services

Effective July 18, 2011, the Department of Medical Assistance Services (DMAS) will require an independent clinical assessment as a part of the service authorization process for Medicaid and FAMIS children's community mental health rehabilitative services (CMHRS). This includes children and youth up to age 21 enrolled in Medicaid and FAMIS fee for service or managed care programs. DMAS will contract with local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) (herein referred to as the "independent assessor") to conduct the independent clinical assessment. The affected children's community-based mental health rehabilitative services are Intensive In-Home (IIH), Therapeutic Day Treatment (TDT), and Mental Health Support Services (MHSS) for individuals up to the age of 21. Each child or youth must have at least one independent clinical assessment either prior to the initiation of the affected services mentioned above or for individuals already receiving services, the independent clinical assessment will be required as part of the first service re-authorization process. Children and youth who are being discharged from residential treatment (DMAS Levels A, B, or C) do not need an independent clinical assessment to access IIH, TDT, or MHSS. They are required to have an independent clinical assessment as part of any subsequent service reauthorization.

An independent clinical assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for one of the affected CMHRS services for dates of service beginning on or after July 18th, 2011. New services are defined as CMHRS services for which the individual does not have a current service authorization in effect as of July 17, 2011. Independent assessors shall meet the DMAS definition of a licensed mental health professional including persons who have registered with the appropriate licensing board and are working toward licensure.

Effective September 1, 2011, a completed independent clinical assessment will be required for those individuals up to the age of 21 who are currently receiving services and whose service re-authorization is due for dates of service on or after September 1, 2011 for IIH, TDT, and MHSS. CSBs/BHAs will conduct independent clinical assessments on and after August 1, 2011 for service re-authorizations with dates of service continuing on and after September 1, 2011.

For children and youth currently receiving Intensive In-Home, Therapeutic Day Treatment, or Mental Health Support Services (under 21) and for whom a re-authorization is desired, an independent clinical assessment must be conducted within the thirty (30) days prior to the current service authorization expiration date. The provider of services shall inform the parent/legal guardian in writing at least 30 days prior to the current service authorization expiration date that an independent clinical assessment is needed. To facilitate the process, providers should encourage parents/legal guardians to call for an appointment as early as possible. The independent clinical assessment must be completed and submitted to KePRO by the independent assessor prior to the service provider submitting the service re-authorization request to KePRO, or the request will be administratively rejected. A copy of the independent clinical assessment must be in the service provider's client's file.

Levels A and B Residential Services will follow these same requirements effective in November 2011. Providers will be notified 30 days in advance when this requirement is implemented. Please note that Mental Health Support Services and Levels A & B Residential Services are not a covered benefit for MCO FAMIS enrollees.

#### ***The Independent Assessment Process***

1. A parent or legal guardian of a child or youth who is believed to be in need of one of the affected community-based mental health rehabilitative services must contact the local CSB/BHA to request an independent clinical assessment. If a service provider receives a request to provide one of the affected services, the service provider must refer the parent/legal guardian to the local CSB/BHA first to obtain the independent clinical assessment. The independent clinical assessment must be completed prior to service initiation. (Please see the behavioral health section of the DMAS website [www.dmas.virginia.gov](http://www.dmas.virginia.gov), for a list of CSB/BHA contact information.)

If the child or youth is in immediate need of treatment, the independent assessor will make a referral to appropriate, currently reimbursed Medicaid emergency services in accordance with 12 VAC 30-50-226 and may also contact the child or youth's MCO to alert the MCO of the child's needs.

2. Once the CSB/BHA is contacted by the parent or legal guardian, the independent clinical assessment appointment will be offered within five (5) business days of a request for IHH Services and within ten (10) business days of a request for TDT and MHSS. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian. CSBs/BHAs will attempt to accommodate working schedules of parents and legal guardians. Medicaid transportation may be used to transport the child or youth and parent/legal guardian to the independent clinical assessment appointment.
3. The independent assessor will conduct the independent clinical assessment with the child or youth and the parent or legal guardian using a standardized format and make a recommendation for the most appropriate, medically necessary services, if indicated. Only the parent or legal guardian and child or youth will be permitted in the room during the independent clinical assessment. Recommendations may include community mental health rehabilitative services, psychiatric, or outpatient mental health services.
4. The independent clinical assessor will inform the parent or legal guardian about the recommended service options and their freedom of choice of providers. The family or legal guardian will be asked if they have a service provider in mind for the recommended service(s). If a service provider has been identified, the independent assessor will note the choice of service provider on the Choice form. In

addition, the independent assessor will ask the parent or legal guardian to sign a release of information if the parent agrees to share clinical assessment information with the chosen service provider(s). If a service provider has not been identified, the independent assessor will provide the parent or legal guardian with a provider list generated by DMAS. For outpatient mental health services, the independent assessor will provide the parent or legal guardian with a provider list generated by the child or youth's MCO or, for individuals in the Medallion program, the parent or guardian can contact the primary care physician.

5. The independent assessor will electronically submit the independent clinical assessment summary data within one (1) business day of completing the assessment into the KePRO iEXCHANGE™ service authorization system. KePRO will process the independent clinical assessment and will batch this information into the MMIS. The independent clinical assessment will be effective for a 30 day period. The independent assessor will complete assessment documentation within three (3) business days.
6. If a community mental health service has been recommended, the parent or legal guardian will choose and contact a service provider. Prior to the initiation of treatment, the CMHRS service provider must request a copy of the findings of the independent clinical assessment. If the parent or legal guardian consents to the release of information, the independent assessor will mail, fax or send a copy of the independent clinical assessment to the service provider within five (5) business days of the request. The service provider (supported by the independent assessment) will then conduct a service specific assessment for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Support Services (H0032, U8) and develop an initial service plan. (Please refer to Chapter IV of the CMHRS Provider Manual for complete guidance.)
7. If the selected service provider concurs that the child meets criteria for the service recommended by the independent assessor, the selected service provider will submit a service authorization request to KePRO. A copy of the independent clinical assessment must be in the service provider's client's file. **The service provider's service specific assessment for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Support Services (H0032, U8) must not occur prior to the mental health independent assessment.**
8. If a service provider identifies the need for additional services not included in the independent clinical assessment that is clinically indicated due to a significant change in the child's life that occurred after the independent clinical assessment, the service provider must contact the independent assessor and request a modification within thirty (30) days of the completion of the independent clinical assessment. If the independent assessment is greater than thirty (30) days old, another independent clinical assessment must be obtained prior to the initiation of a new CMHRS service. Examples of a significant change include hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent/legal guardian.

***Service Authorization Process for Community Based Mental Health Rehabilitative Services***

The current process for requesting service authorizations from KePRO remains the same with one exception. The authorization checklists have been revised to include new independent clinical assessment questions. (Please see *The Community Mental Health Rehabilitation Services Manual, Appendix C.*) If the provider submits a service authorization request without record of having a current (within 30 days) clinical independent clinical assessment, KePRO will administratively reject the request. An independent clinical assessment must be obtained prior to re-submitting the request and initiating services since it is a required component of the service authorization process.

- If the independent assessment does not recommend the requested service and the service provider agrees with the independent clinical assessment recommendation, no service authorization request will be submitted to KePRO. If the service provider documented a significant change in the child’s life since the independent clinical assessment that may change the independent assessor’s recommendation, the service provider must contact the independent assessor to discuss the recommendation. The CSB/BHA may modify the independent clinical assessment as deemed necessary. All modifications must be submitted to KePRO electronically via iEXCHANGE™ prior to the submission of a service authorization request for that service.
- If the independent assessor does not recommend the service and the parent/legal guardian disagrees with the recommendation, the parent/legal guardian may approach a service provider requesting the service. If, after conducting the service specific assessment, the service provider identifies additional documentation beyond the independent clinical assessment that demonstrates the service is clinically indicated, the service provider may submit a service authorization request to KePRO. KePRO will review the service authorization submission and the independent assessment, and make a determination. If the determination results in a service denial, the member and service provider will be notified of the decision and the appeals process.

**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](http://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.

**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. <a href="http://www.passporthealth.com">www.passporthealth.com</a> <a href="mailto:sales@passporthealth.com">sales@passporthealth.com</a> Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX <a href="http://www.hdx.com">www.hdx.com</a> Telephone: 1 (610) 219-2322	Emdeon <a href="http://www.emdeon.com">www.emdeon.com</a> Telephone: 1 (877) 363-3666
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**“HELPLINE”**

The “HELPLINE” is available to answer 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 call.