



Department of Medical Assistance Services
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Richmond, Virginia 23219

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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: 7/23/2010

SUBJECT: Changes to Community Mental Health Rehabilitative Services – **Adult-Oriented Services**, July 1, 2010 & September 1, 2010 **This memo replaces the Changes to Community Mental Health Rehabilitative Services Memo dated June 9, 2010.**

The Department of Medical Assistance Services (DMAS) is releasing this revised replacement memo to clarify the June 9th memorandum. This provider memo addresses only adult oriented services.

Effective July 1, 2010 and also, September 1, 2010, DMAS will implement new requirements for Community Mental Health Rehabilitative Services (CMHRS) (also referred to as state plan option services) specifically Mental Health Support Services, Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, and Intensive Community Treatment, Crisis Stabilization, and Crisis Intervention. The changes include new requirements for service delivery and adherence to DMAS marketing/outreach rules. These changes are made to ensure quality services for individuals 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 or 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 reimbursement.

Changes Effective July 1, 2010

DMAS will adopt the following requirements:

Marketing/Outreach

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

Case Management/Primary Care Provider Coordination

2. 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. The provider must also inform the primary care provider of the client's receipt of community mental health rehabilitative 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.

3. These changes were reflected in the Community Mental Health Rehabilitative Services Manual in July 2010 and are now posted on the web site.
4. 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 individuals.

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.

Mental Health Support Services, Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, and Intensive Community Treatment, Crisis Stabilization, and Crisis Intervention

The effective date for the following qualifications is Sept. 1, 2010, but providers will have until March 1, 2011 (6 months) to ensure staff employed prior to September 1, 2010 comply with new qualification requirements. Staff hired September 1, 2010 or after must be in compliance with the new requirements.

1. Any staff person hired as a QMHP on or after September 1, 2010, may no longer qualify as a QMHP (under the Mental Health Worker category) with four (4) years of experience as the only criteria. The new staff person must qualify under one of the other defined QMHP categories or as one of the other Mental Health Worker qualifications. The other QMHP categories are physicians, psychiatrists, psychologists, social workers, registered nurses, and Mental Health Workers. Mental Health Worker is defined as:
 - a. an individual with a bachelor's degree in human services, a related field, or other degree deemed equivalent to those described, from an accredited college and with at least one year of clinical experience; OR
 - b. a Registered Psychiatric Rehabilitation Provider (RPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA) as of January 1, 2001; OR
 - c. an individual with at least a bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field and who has at least three years clinical experience; OR
 - d. an individual with at a least bachelor's degree from an accredited college and certification from the United States Psychiatric Rehabilitation Association (USPRA) as a Certified Psychiatric Rehabilitation Practitioner (CPRP); OR
 - e. an individual with at least 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 who has at least three years clinical experience.

2. In order to allow providers to develop QMHP staff, a new QMHP category will be created, "QMHP eligible," effective September 1, 2010. This category is created to allow staff with a Bachelor degree the ability to provide services and gain clinical experience under supervision. Staff must have the following credentials:
 - a. At least a Bachelor's in a clinical field without one year of clinical experience
 - b. A Bachelor's in a non-clinical field and is enrolled in a Master's or Doctoral clinical program and 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 5% of total clinical adult staff in agency. The QMHP eligible staff must have at least one hour of licensed mental health provider (LMHP) supervision per week which must be documented in the employee 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 duplication of supervision time. Evidence of compliance with the QMHP eligible criteria must be in the staff 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 before September 1, 2010.

Variance Requests

3. Until February 11, 2011, a provider may request a variance for staff that do not have a bachelor's degree but who have at least four year's experience in providing behavioral health services. At this time, there will not be a limit on the number of variances allowed for adult services. The adult services are Mental Health Support Services, Day Treatment/Partial Hospitalization, Psychosocial Rehabilitation, and Intensive Community Treatment, Crisis Stabilization, and Crisis Intervention. Variance requests will be submitted to DMAS and evaluated with consultation from DBHDS. 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 10 business days. If a variance request is granted 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 variances shall not be accepted after February 11, 2011.

Mental Health Support Services:

1. The initial assessment (H0032, U8) and the six month re-authorization must be done face-to-face by the LMHP or a license-eligible mental health professional. The six month re-assessment for the service provision (H0046) must be done face-to-face by the LMHP or the license-eligible mental health professional. The QMHP must meet face to face with the LMHP or the license-eligible mental health professional supervisor to review the ISP at least quarterly.
2. This review must be documented in the client record.

These changes will be reflected in the Community Mental Health Rehabilitative Services Manual in September 2010.

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: (4)

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

Marketing Attachment

“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.

2. **Requirements to Ensure Compliance**

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.