Public Comments

Mississippi Division of Medicaid

MS SPA 20-0022 Mental Health Service Coverage and Reimbursement

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September 25, 2020
MS Association of Community Mental Health Centers

Margaret Wilson, Office of
Policy Division of Medicaid
Office of the Governor
Walter Sillers Building, Suite
1000 550 High Street
Jackson, MS 39201

Re: Comments on Medicaid SPA 20-0022 Mental Health Coverage and Reimbursement

Ms. Wilson,

Thank you for the opportunity to submit comments on Medicaid State Plan Amendment (SPA) 20-0022. In accordance with the guidance provided at https://medicaid.ms.gov/news-and-notices/public- notices/, the Mississippi Association of Community Mental Health Centers (MACMHC) respectfully submits the following questions and comments. If you have any questions, please contact Lisa Henick, MACMHC CAO, at lisahenick2017@gmail.com.

General Questions:

1. Is it the Division of Medicaid's intent to modify the existing fee schedule? We need clarification on the 5% assessment and if the fee schedule will change.

2. Throughout the SPA document, PCMHTs are left off the list of acceptable providers. Can PCMHTs bill for services? Clarification is needed throughout the body of the SPA when it specifies the certification of staff not including provisionally certified therapists and CSS, etc.

3. Rule 2. d. 6.a. leaves off LCMHTs.

4. Rule 3. F. adds CSS and CPSS to the staff; no need for these individuals to be added to the CSU staff, as they are available to assist with the transition post discharge.

5. Under Crisis Residential Services, language for Crisis Response Services (M-CeRT) is incorporated under Crisis Residential (3.f). Crisis residential does not require CSS, CPSS or Master's level Crisis Response Coordinator.

6. Crisis Response Coordinator for Crisis Residential Services is not a position that we have heard of in the past.

7. Does PSR/Senior PSR have to be provided by a Master's level clinician as stated in 15.f or as referenced by DMH standards 24.1.K (Master's on-site 5 hours/week)?

8. I also don't see where IOP and/or A&D Residential is addressed. We thought these services were going to be incorporated based on previous dialogue/requests.

9. For PACT (e) it says must be provided by a CMHT, LPC, etc. It does not mention provisionally licensed staff. I noticed that on other services so we need some clarification on that. This was located in the section that was crossed out: The Division of Medicaid does not provide reimbursement for crisis response services provided by provisionally certified staff.

10. As copied from the Medicaid posting, it appears that we need additional staff at the CSU however DMH's 2020 Operational Standards only require 1 FT Director, 1 FT MH Therapist and 1 direct service personnel to (4) people (our DCWs). The RN must be on site all shifts and can be counted in the staffing ratio. Our current staffing meets the DMH ratio but does this mean we would need to hire a PSS and CSS? Plus, is the 1 MH therapist sufficient even though she's not considered a Crisis Response Coordinator or would that be the Mobile Crisis Response Coordinator or myself as the Crisis Services Director and us just be available for consultation? The Crisis Residential Services Provider must have the following staff in the ratios required by DMH: An immediately available psychiatrist, PMHNP, or psychologist; Facility Director; A full- time RN; Community Support Specialist; Certified Peer Support Specialist; Master's level Crisis Response Coordinator; and Other Master's level staff.

11. In Attachment 3.1A Exhibit 4b Page 6 regarding MYPAC services, the TN No. 2002-28 (left hand bottom corner) standard #3 reads:

Mississippi Youth Programs Around the Clock (MYPAC) services are covered for EPSDT-eligible beneficiaries when prior authorized by the UM/QIO or designee and the service and provider meet the following....

However, the TN No. NEW standard #3 reads Mississippi Youth Programs Around the Clock (MYPAC) services are covered for EPSDT-eligible beneficiaries when the service and provider meet the following....

and the following is struck through on the same page:

~~Prior authorization may be requested through the submission of an authorization request by a qualified Medicaid provider. Additional documentation to substantiate medical necessity may be requested by the Medicaid Agency.~~

I am not sure what this means because PAs are still required as far as we know. Has it been moved to a different section?

12. Where is TCM information?

13. What about P-LPC's? They are not listed anywhere.

Specific Comments on the SPA 20-0022 document (please note comments in red font)

A. Replacing IOP psychiatric service with ICORT (#17)

B. Reimbursing ICORT at current IOP rate (a per-diem of $122.54/day from fee schedule)

C. Including reimbursement language for Early and Periodic Screening, Diagnosis and Treatment) EPSDT mental health services which are not being revised. Birth to 21 without regard to service limitations and with PA **(Attachment 3.1-A Day Treatment Wraparound Facilitation & MYPAC)**

D. Allowing providers of EPSDT services to provide non-EPSDT beneficiaries with mental health services.

E. Adding Acute Partial Hospitalization in an outpatient department of a hospital or other provider certified by the DMH or other appropriate entity as determined by DOM.

F. Adding service for those with single diagnosis of SUD

G. Removing annual service limits for Crisis Response Services and Medication Administration

H. Increasing the rate for Mental Health Assessments by a non-physician to 90% of the Medicaid physician rate for Psychiatric Diagnostic Evaluations.

PCMHT's are not mentioned in old SPA

ASSURANCES:

If Medicaid service limits are reached – **CMHC's** must continue to see people on a sliding fee basis. Participants have freedom of choice of enrolled providers, and staff within agencies.

Does not include other providers to continue services on sliding fee.

PROVIDER REQUIREMENTS:

Adds all the private licensure of MS board eligible and above; psychiatrists, MS MDs, PA, PMHNP with MD collaborative relationship with MD with established protocol or practice guidelines, MS licensed Psychologists, LCSW, LPC.

CMHC – All above and LMFT, Professional Art Therapists, RN, LPN,

DMH certified staff: CMHT CIDD, CAT, CSS with bachelors and with supervision;

Page 3 - Peer support with GED or HS diploma and supervision – includes supervision under a person trained as PEER support supervisor

d.6.(d) – does this allow for grandfathering of the individuals who may be trained to be supervisors with a bachelor's degree? Or does a PEER support supervisor have to be Masters' level?

DMH certified staff and DMH certification may cover the Provisional since that entire section has been removed.

No mention of Wraparound facilitators. –Moved to **Attachment 3.1-A, Exhibit 4b, Page 5**

C. Rehab Services removes "to all eligible individuals"

1. Treatment Plan and Review:

Much more general – takes out the clinical team requirements and just says appropriate professionals within their scope of practice

Same approval signatures – LCSW, LPC, LMFT and above

2. **Crisis Response Services:** *MOVED FROM #12 TO #2*

More general and unlimited service units – can PCMHT and PLPC be part of this if trained. CSS is bachelors and PCMHT and PLPC are Master's level as well as Peer Support and it appears we can bill for their time, what about PCSS and PPSS?

3. **Crisis Residential:** *MOVED FROM # 13 TO #3*

A & B. Just clarifies the old A & B the services to be provided

F. Can this Crisis Response Coordinator be the same employee for the Crisis Response Services?

4. **Community Support Services:** *MOVED FROM #15 TO #4*

Old #1 is resource coordination NEW is #6 spells out the resources that may be needed. OLD #5 is not included in NEW – visits for the purpose of monitoring

NEW #1 Identify the strengths and needs of the person

NEW #2 includes therapeutic interventions that increase skill acquisition Need clarification as CSS has not been a therapeutic intervention

New #10 Facilitation of the ISP – what does this look like? Is this wraparound?

f. daily limit (6 units) is deleted – same yearly limit

5. **Medication Evaluation and Management** *MOVED FROM #2 TO #5 and RENAMED*
Pulled out Medication administration into its own item Removed the limits of 72 on CMHCS and PMHCs

6. Medication Administration - New Section
Pull it from #5 – no limits

7. Psychiatric Diagnostic Evaluation – New Section
A integrated biopsychosocial assessments including history, mental status and recommendations.
b. diagnosis emotional, behavioral or developmental disorders
c. Must be provided by physician or other licensed practitioner operating within their scope of license and practice
d. four units per state fiscal year (DEFINE A UNIT)

8. **Psychological Diagnostic Evaluation** *Moved from #4 to #8 and added Diagnostic in title*
c. other licensed practitioner within their scope of license and practice.
d. Changed from 4 hours to 4 units per fiscal year (DEFINE UNIT)

9. Mental Health Assessment by Non- Physician – USED TO BE #3 PSYCHOSOCIAL ASSESSMENT -
C. ARE PCMHT AND PLPC INCLUDED AS ASSESSORS
D. limited to 4 units (define UNIT)

10. Brief Emotional/Behavioral Health Assessment – New Section
a. brief screening using standardized assessments
b. to identify the need for more in-depth assessment
c. Trained or certified to provide the assessment
d. limited to 12 per year.

11. **Nursing assessment –** *Moved from 5 in old to 11*
NO changes at all

12. **Individual psychotherapy-** *Moved from 6 in old to 12*
e. specifically states limit to 36 when NOT provide with E/M. Individual complexity has to be medically necessary. DOES THIS MEAN IT CANNOT BE PROVIDED ON THE SAME DAY AS E/M OR JUST NOT BY THE SAME PROVIDER?

13 Family Psychotherapy – *Moved from 7 in old to 13*
No changes – spells out that the service is covered with or without beneficiary present.

14. Group Therapy/Multi-Family Group Therapy –*Moved from 8 in the old to 13*
No real changes

14. **Acute Partial Hospitalization Services -** # 14 HAS ALREADY BEEN USED - Used to be # 11 in old
a. re written and removed community based service
c. added Family therapy and removed skill building
groups d has been added to include other providers

15. **Psychosocial Rehabilitation (PSR)-** *Moved from #9 to 15*
a. does state the program must meet DMH standards
c. removed Individual therapy
c. put treatment plan and development under d.
No mention of Bachelor level person being able to run the program.

16. **Program of Assertive Community Treatment (PACT) Services –** *Moved from #18 to #16*
A mentions one purpose to be psychosocial Rehabilitation, however; the beneficiary cannot attend PSR if being served by a PACT Team.
d.1.Team leader have DMH credential as a CMHT or professional license (can a PCMHT serve on team)
d. gives the composition of the team to include the employment specialist, Certified Peer support,
e. does not include those team members in the people to provide the services
g. removes the daily limit, but the annual limit of 1600 units remains. 1600/4 = 400 hours

PACT	**VS**	**ICORT**
Clinical purpose to provide community based interdisciplinary care to improve the beneficiary's overall functioning at home, work, and in the community.		Clinical purpose to assist in keeping people receiving the service in the community in which they live avoiding placement in state operated behavioral health service locations.

17. **Intensive Community Outreach and Recovery Team (ICORT) Services –** NEW SECTION taking the place of Intensive Outpatient Psychiatric Services
Addresses the A & B of the beginning of the SPA
f. Must have a PA
g. Service limit to 270 days per year

WHAT IS THE BILLING CRITERIA ON THIS TO BE ABLE TO BILL THE PER DIEM?

18. **Peer Support –** *Moved from #14 in old to #18*
a. adds the individuals with SUD
c. changes treatment plan to recovery support plan
f. removes daily limit but keeps annual limit of 200 15 minute units

Day Treatment is not addressed in this document Moved to Attachment 3.1-A Exhibit 4bB page 4 Wraparound is not mentioned in this document moved to Attachment 3.1, Exhibit 4b, Page 5.

Attachment 3.1-A

Changed from under 21 to EPSDT-eligible participants

Day treatment – moved from Attachment 3.1-A Exhibit 13.d page 9 to Attachment 3.1-A Exhibit 4b page 4

1.a. removed the verbiage that Day treatment is the most intensive outpatient program for individuals under the age of 21
b. took out educational development
c. Service components
REMOVED Individual therapy
Group Therapy
LEFT in Treatment Plan Development and review Skill building groups…….
1.d. must be certified by DMH
1.e. staff able to provide Day Treatment do not mention PCMHT, but does include CMHT

Wraparound Facilitation – in Attachment 3.1-A, Exhibit 4b, Page 5
2.a. changed from develop and implement of a treatment plan to creation and facilitation of a child/youth family team for the purpose of developing one plan
2.d. spells out the requirements of a wraparound facilitator
2.f. removes the daily limit of 16 units per day and leaves the 200 units per year.

3. MYPAC services
Now say that wraparound and community support must be certified by DMH and MYPAC provider through Medicaid.

Attachment 4.19-B

They contradict themselves about when the 5% came in to play and when the published rates reflected the 5% - 10 year difference – it may be because of the service and when it began?…

page 4b(2)
ADDED the language about the 5% and "has been in effect since July 1, **2002** and the fee schedule already incorporates the five % reduction."

Page 4b(5) ADDED and "has been in effect since July 1, **2012** and the fee schedule already incorporates the five % reduction."

6.d is the first place where the reducing for any service by five 5% of the allowed amount for that service. DELETED and

ADDED the language about the 5% and “has been in effect since July 1, **2002** and the fee schedule already incorporates the five % reduction.”

Page 13 DELETED an entire paragraph about the 5% reduction after published rates. And added and “has been in effect since July 1, **2012** and the fee schedule already incorporates the five % reduction.”

DEPARTMENT OF MENTAL HEALTH

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Diana S. Mikula - Executive Director

September 25, 2020

Margaret Wilson, Office of Policy
Office of the Governor, Division of Medicaid
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Jackson, MS 39201

Dear Ms. Wilson:

The Mississippi Department of Mental Health has reviewed the Medicaid SPA 20-0022 Mental Health Coverage and Reimbursement and appreciate the opportunity to provide the following comments:

- 3.f.1-7 (page 5) Crisis Residential Services- DMH Operational Standards does not list or require a Community Support Specialist or a Peer Support Specialist as part of the staffing for Crisis Residential Services.

- 14. Acute Partial Hospitalization Services (page 10)
  d. DMH requests clarification that "other appropriate entity as determined by the Division of Medicaid" is not under the oversight of DMH.

- Clarify if Intensive Community Support Services will be included in the current or future SPA Amendments.

We look forward to continuing our partnership and work with the Division of Medicaid. Please feel free to contact me for clarification or questions at 601-359-6285 or Sandra.parks@dmh.ms.gov.

Sincerely,

Sandra Parks, Bureau Director
Certification and Quality Outcomes
MS Department of Mental Health

cc: Diana Mikula
Steven Allen
Wendy Bailey
Jake Hutchins

September 28, 2020

Ms. Margaret Wilson
Office of Policy
Division of Medicaid
Office of the Governor
Walter Sellers Building
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Jackson, MS 39201

Submitted via email

RE: Oceans Behavioral Health Hospital, Biloxi, MS

Comments on Medicaid State Plan Amendment (SPA) 20-0022

Dear Ms. Wilson:

Oceans Behavioral Hospital of Biloxi is pleased to submit comments on the Medicaid State Plan Amendment (SPA.) 20-0022 to improve the Plan. Our comments follow:

Ocean wants to improve the health outcomes of Medicaid's at-risk beneficiaries in a fiscally responsible manner. Following a thorough review of the Medicaid State Plan Amendment (SPA) 20-0022 by both Oceans clinical services and reimbursement teams, we submit the following observations and concerns:

- Intensive Outpatient (IOP) and Partial Hospitalization Programs (PHP) are distinctively different levels of care.
- The Proposed Regulations eliminate the traditional Intensive Outpatient Programs (IOP) and offer Partial Hospital Programs (PHP) as the ONLY outpatient care available to Medicaid beneficiaries following their discharge from a free-standing psychiatric hospital.

I. 13.d.C.14 Acute Partial Hospitalization Services

A. The Joint Commission Standards for PHP services require the inclusion of a measurement-based care instrument as part of the treatment, which is to be included in the treatment plan. The instrument provides an outside measurement to demonstrate the effectiveness (or lack thereof) of the treatment plan for each patient. The instrument is reviewed throughout the treatment process to track the patient's scores.
B. The Proposed Regs require prior authorization of PHP Services by either a UM or QIO; however, they do not specify how frequently any reauthorization would be required. The industry standard is 30/60 days for reauthorization.
C. The Medicare Regs require the provision of 3 clinical services per day to qualify for full reimbursement. SPA 20-0022 requires a minimum of 4 hours of service per day for PHP Services

Reimbursement. The challenges of this patient population, including but not limited to transportation, create an enormous disincentive for providers to admit patients to the program. These patients may benefit from the program, but require increased flexibility to fully participate.

D. Given the current status of COVID-19 Restrictions, and the Centers for Medicare and Medicaid Services' ("CMS") Section 1135 ("Mississippi Waiver"), providers must be given the flexibility to provide PHP services via telemedicine.
E. Education and Training Services are recognized as the most effective treatment in PHP Services. This intervention is omitted from SPA 20-0022. We recommend the inclusion of Education and Training Services as a reimbursable modality.
F. PHP is an intermediate level of outpatient care to assist the patient in the transition from acute to more traditional outpatient services. Without a conventional IOP benefit, 100 days of care per annum is not enough care to allow these patients to attain and maintain their treatment goals.
G. The Medicare base reimbursement rate is $238.64 per day for PHP Services, and we propose the Medicaid rate be similar to the Medicare rate.

II. Section 17- Intensive Community Outreach and Recovery Team (ICORT) Services

SPA 20-022 requires the provision of ICORT Services by Community Mental Health Centers (CMHCs). Medicaid patients have the highest acuity of any patient in the mental health system. Restricting Medicaid patients' ability to continue receiving their care from the providers who treated them during their inpatient hospital stay is unconscionable and not required by any other payor. The Regulations continue to direct Medicaid patients to facilities that are not consistently able to provide timely care.

A. The Joint Commission requirement of Measurement-Based Care submitted in the PHP Section of these comments should be included in the ICORT Services Section for the stated reasons.
B. The addition of the requirements of peer support services and skill-building groups require the addition of the following staff:
   - Team Leader;
   - Licensed Master-Level CMHT;
   - Certified Peer Support Specialist;
   - Community Support Specialist; and
   - Clerical Support Person.
C. Peer Support Services and Skill Building Group Services are generally not within the scope of services provided in an IOP program. While the addition of these services is an admirable goal, the cost is an enormous burden for the level of Medicaid reimbursement provided and limits valuable group interaction therapy.

III. Community Mental Health Centers Collaboration with Willing Providers

A. SPA 20-0022 requires CMHCs to provide multiple types of services, some of which may already be available in the community from other providers. Expansion of these regulations to allow CMHCs to collaborate with free-standing psychiatric hospitals and other community providers would be beneficial to both the patients and the State's Medicaid budget.
B. It is respectfully requested the addition of a section on CMHC Collaboration to be included in the final version SPA 20-0022.

Following your review of Oceans' comments, we would be pleased to answer any questions you may have.

Respectfully submitted,

Oceans Behavioral Health Hospital of Biloxi

By Its Special Counsel

Cox Law Group, PLLC

James T. Cox, J.D.

Cc: Drew Snyder, J.D.

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Mr. Jim Thompson

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