MISSISSIPPI DIVISION OF MEDICAID

Mississippi Administrative Code Title 23, Part 223, Rules 1.3, 1.5, 1.8, 2.5, and 6.1-6.6

The following individuals requested an Oral Proceeding:

John Morgan Hughes, Executive Director, MACCA
Tanyeka Anderson, Board Member, MACCA
Sean A. Milner, Executive Director, Baptist Children's Village
John D. Damon, Ph.D., Chief Executive Officer, Canopy Children's Solutions
Wanda Thomas, LCSW, Executive Director, Catholic Charities
Janice Wilder, LSW, CCJS, Executive Director Christians in Action, Inc.
Jackie Smith, Executive Director, Faith Haven, Inc.
Tina Aycock, Executive Director, Hope Village for Children, Inc.
Devon V. Loggins, LCSW-S, Chief Executive Officer, Methodist Children's Homes
Sheila G. Brand, Executive Director, Sally Kate Winters Family Services
Jamie C. Himes, President and CEO, Southern Christian Services for Children and Youth, Inc.
Rhonda Stempkovski, Youth Villages
Andrew Redd, Executive Director, Berrean Children's Home

Public Comments:

May 14, 2021
Drew Snyder
Division of Medicaid
Office of the Governor
550 High Street, Suite 1000
Jackson, MS 39201
Director Snyder,
We would like to express our concerns regarding the proposed changes to the Mississippi Around the Clock (MYPAC) program. For more than 14 years, MYPAC has provided effective help to thousands of Mississippi children and families; we have grave concerns about the changes that could be made within weeks.
The proposed regulation changes would be devastating to Mississippi children and families, ending the most successful community-based mental health program that the state has ever had.
If MYPAC is eliminated, it will leave Mississippi Medicaid without a proven intensive in-home service option. This will undoubtedly negatively impact the state's budget, as many children who could receive effective services in their own homes with their families would instead be placed unnecessarily in costly psychiatric residential treatment centers and psychiatric hospitals.

Eliminating MYPAC will also reinforce the fundamental narrative in current litigation against the state regarding Mississippi's lack of mental health services overall and over-reliance on institutionalization. This will not only threaten Mississippi's ability to successfully exit already existing lawsuit judgements but may open the state to additional lawsuits.

The development of the MYPAC program brought Mississippi national acclaim as a leader in children's mental health services. Its elimination would give the perception that the state is moving backwards and reducing needed mental health services for our children.

The cost to families and the state

When proposing this change, some are highlighting cost savings as justification. However, that's faulty comparisons. All youth served by MYPAC must have a psychiatrist recommendation stating that their behavioral and psychological needs are so extreme that they are a risk to themselves and others and meet the level of need for psychiatric inpatient care in a Psychiatric Residential Treatment Facility (PRTF). MYPAC was designed to help the state's highest risk, highest need children and youth without costly out-of-home placements.

Without MYPAC services, young people will be removed from their homes and placed in long-term residential services. Due to increased utilization of residential services, since effective diversion services will not be available, Mississippi will see a significant increase in PRFT and institutional costs. PRTF services are very expensive and do not produce the same positive outcomes that comprehensive community-based services do for a much lower cost.

PRTFs also have high rates of recidivism, meaning young people experience multiple PRTF placements due to behavior changes not being sustainable when they returned home. This happens frequently because behavior change in a controlled residential setting does not affect the youth's home environment, including peer and family functioning. Without intensive services to help youth transition home quickly and safely when an out-of-home placement is necessary, the state will also see an increased length of stay in these costly PRTF placements.

Family bonds and attachments weaken when children face multiple, lengthy residential stays. This often results in children entering state's custody, which can in turn put a strain on Mississippi's foster care system. Each child removed from the home experiences trauma from that removal, which is shown to have negative long-term impacts. Studies have shown that children who experience multiple foster care placements have more PTSD than military veterans.

Today, across the state, around 1,000 youth are safely and successfully receiving MYPAC services in their own homes. Does Mississippi have the residential capacity to place hundreds of children in in-state facilities if MYPAC is abruptly discontinued? This proposed change could also increase the reliance on out-of-state placements, which can further separate youth from their families and communities of origin.

Innovation and intensive support for families

MYPAC was created in 2007 through the Center for Medicare and Medicaid's five-year Community Alternatives to PRTF Demonstration Grant Program. This demonstration was designed to determine if children who qualified for residential treatment could be helped more successfully at home. The answer was yes -- and MYPAC put Mississippi in the forefront of offering innovative, evidence-based programs for children and families. For 14 years, the program and its success have been a bright spot for the state amid lawsuits around the state's child-serving systems.

Innovation was at the center of the creation of MYPAC; Mississippi used the demonstration grant as an opportunity to ensure that the highest need children receive support across each life domain. The family-centered nature of MYPAC services creates multiple areas of impact. MYPAC's holistic approach impacts youth and family functioning in the home, school, and community environment. MYPAC engages the family and the community in services, creating an environment that is supportive of long-term behavior modification. Work extends beyond the

identified client to impact parents, siblings, extended family, peer groups, and others who are directly involved in the child's life.

With MYPAC services, the state is purchasing an outcome, not just a service. The intent and purpose of MYPAC is to divert youth from PRTF and out-of-home placements. No other service definition is linked to an actual outcome or program goal. MYPAC fills a critical gap that often exists in mental health systems. Removing MYPAC from the Medicaid service array will remove the only comprehensive community-based service in Mississippi. Parents will not have access to the services and support needed to maintain their children safely in their homes, which means the number of kids in state custody will also rise.

Changing the reimbursement model may eliminate service providers

Instead of comprehensive, intensive services through MYPAC, Medicaid proposes going back to an a la carte fee-for-service system that did not work for the state's children and families 14 years ago -- and it will not work now.

Changing the reimbursement model does not change the actual cost of service delivery, it just threatens the sustainability of providers who are willing to do this work. Rate increases and other structural changes will not address key elements of comprehensive service provision, such as 24/7 on-call support, drive time, access to medication management, etc., that are not covered by a la carte service delivery. The state should consider the increased cost of additional, more intensive services if youth do not receive the therapeutic interventions needed to modify their behaviors or treat their symptoms and prevent further escalation.

Dissolving MYPAC as the only comprehensive community-based service will have an overall negative impact on service delivery. It is impossible to deliver the same level of intensity as MYPAC using ad hoc therapeutic services. This model will not guarantee that the same provider will provide all therapeutic services a family needs – creating disruptions in clinical treatment and the therapeutic relationship between the provider and the youth and family. This is further limited by current service caps and maximum units allowed that do not allow for the same type of intensity. Some therapeutic services cannot be billed during the same day, causing issues with comprehensive service delivery and critical model elements, including 24/7 in-person crisis response and clinical consultation, which are not encounterable under traditional fee-for-service codes.

Moving to a fee-for-service model will have an incredibly negative impact on Mississippi's families and services providers. If MYPAC is removed from the administrative code, numerous providers will not be able to sustain program operations through fee-for-service billing. The system will see the impacts of this quickly, as fewer providers will be willing to provide mental health services, especially in rural areas because driving time will no longer be accounted for in the cost model, for example.

Additional negative outcomes and impacts associated with a fee-for-service model include:

- Incentivizing quantity over quality of services – Fee-for-service incentivizes providers to provide services based on the most advantageous billing scenarios. For example, a clinical assessment shows that a young person is in need of both individual psychotherapy and targeted case management services in order to cope with his ADHD diagnosis. An individual therapy session in a fee-for-service environment is reimbursed as a single unit, which means that a provider only submits one claim to bill one code, at a rate of over $100/unit. However, targeted case management is a 15-minute unit and reimbursed at a significantly lower rate. For the same 60 minutes of service, a provider would have to submit a claim for multiple units and would barely make half of what they could receive for an individual therapy session. The difference in reimbursement rates and units causes some providers to focus on providing only the services that result in higher reimbursement, creating an environment where the holistic needs of children and families are not met.
- Service definitions drive service provision vs the needs of the youth and family – Each Medicaid reimbursable service (i.e. individual therapy, targeted case management, etc.) is linked to a very

specific service definition that defines how a service is to be delivered, what interventions can be provided under that definition, etc. If a provider has scheduled a 60-minute individual session with a youth, but there has been a lot of conflict with the guardian in the home the provider will have to decide whether to continue with the individual session (not addressing the complete issue in the home) or to include the guardian, which would make this session a family therapy session – which is also reimbursed at a lower rate. The concern is that some drivers of behavior or contributing issues will not be addressed because they do not fit under the identified service definition, meaning that youth and families are not receiving the services they need to live successfully long-term.

- Administrative burden on providers – In a fee-for-service environment, providers must track the type of service that is provided per session (i.e. individual therapy versus family therapy), the amount of time spent on each service type provided per session (i.e. 30 minutes of individual therapy and 15 minutes of family therapy), the number of units to bill based on the amount of time spent on each service type, and provide documentation and justification for each unit billed in order to be reimbursed. This is very challenging when providing multiple services in a session to meet the holistic need of the family. For example, a provider arrives at the home for an individual therapy session with the child. Thirty minutes into the individual session, Mom joins (making this now a family therapy session) to talk about concerns in the home, including that there is no food in the refrigerator, and they are late on their electric bill; the provider than spends an additional 30 minutes with the family providing targeted case management services to connect the family with food and utilities resources to make sure the home is safe and basic needs are met. During this one encounter with a family, the provider can bill for individual therapy, family therapy, and targeted case management. All three services will need to be billed separately on their own individual claim with the clinical documentation to explain the service provided and how services aligned not only with the individual treatment plan, but also with reimbursable service according to the service definition.
- Restricts service flexibility and the individualization of services – As previously described, due to administrative burden and prescriptive service definitions, a fee-for-service environment creates a Medicaid system that is very restrictive and does not adapt quickly to the changing needs of youth and families. As previously mentioned, youth who are authorized for MYPAC services meet the criteria for PRFT placements; in addition to the mental health issues of the youth, there are oftentimes other issues or concerns within the family that need to be addressed in order for the youth to safely remain in the home. The MYPAC model was designed to be flexible to meet these individual needs, and this approach has proven successful for Mississippi families for more than a decade.
- Services are rarely linked to achieving positive outcomes – Achieving long-term, sustainable success with youth and families requires a comprehensive approach to treatment. Youth do not live in a vacuum, and any sustainable behavior change must be supported by changes in the youth's natural environment (home, school, extracurricular activities, etc.). In a fee-for-service environment with all services split up and delivered separately, comprehensive service delivery is a challenge.
- Disincentives serving hard-to-engage youth and families – In a fee-for-service environment, most providers operate on very thin margins with little room to allow for non-billable units. This incentivizes providers to only provide services to youth and families who are easy to engage and who are bought in to services – especially services with higher reimbursement rates. Providers are not incentivized to work with youth and families who are disengaged or hard to engage because there is a risk that they will be unable to bill. This means that youth and families who may need services the most are underserved because they are more challenging.

Eliminating mental health services during the pandemic

The timing of the proposal is also a huge concern. Mississippi, like the rest of the country, is still coping with the fallout of the global COVID-19 pandemic. The impacts on the mental health and stability of our most vulnerable children and youth during this time are catastrophic. Destabilizing young people and families currently receiving MYPAC services in the midst of the pandemic will remove their most stable support system. It will also limit or eliminate services to people as they try to rebuild their lives and need a service to provide support to move forward. MYPAC has a proven track record of building long-term, sustainable support systems around vulnerable children and families. This element is critical while families continue to recover from the social and economic impacts of this global pandemic.

Conclusion

This comment is provided to advocate against the proposed removal of MYPAC from Mississippi's Medicaid service array, as it would be detrimental to youth and families, as well as the state's mental health and foster care systems. The evaluation report published in 2012 on the PRTF demonstration grants, under which MYPAC was founded, found the following:

- "Overall, the Demonstration waiver has consistently enabled children/youth to maintain their functional status while in the waiver program. In many instances, program participants had improved level of functioning in several areas. Furthermore, outcomes appear to be improving over time."
- "Over the three waiver years, Demonstration waiver treatment costs totaled no more on average than anticipated aggregate PRTF expenditures in the absence of the Demonstration waiver. Indeed, there is strong evidence that the Demonstration waiver costs substantially less than the institutional alternatives. Over the first 3 waiver years across all states, waiver costs were no more than 32 percent of the average per capita total Medicaid costs for services in institutions – an average per capita saving of $36,500 to $40,000."

The evaluation report noted that Mississippi was one of the top two states that participated in the demonstration in terms of utilization, serving 491 in the first three-year period as a cost of "less than 50 percent of comparable PRTF services."

Mississippi has been ahead of the curve by finding a way to continue to make this vital service available to youth and families across the state. Dismantling this program is a disservice to the children who are currently receiving MYPAC and all those who could benefit from it in the future.

We request that the Division of Medicaid advocate for the preservation of MYPAC. If the program must end, we stand ready to work with the Division and CMS to create an alternative intensive in-home program.

Sincerely,
John Morgan Hughes

May 14, 2021
Drew Snyder
Division of Medicaid
Office of the Governor
550 High Street, Suite 1000 Jackson, MS 39201

Director Snyder,

Thank you for this opportunity to express our concerns regarding proposed changes to the Mississippi Youth Programs Around the Clock (MYP AC) program. We submit these comments recognizing the Division's long-standing and continued intentions to serve the population of children with the best possible services.

The proposed changes to the MYP AC program reverses the positive work the state has achieved over the past 14 year at preventing young people from being needlessly placed in residential facility settings and psychiatric institutions. More troubling, this proposed change comes in the midst of federal scrutiny over the state's over-reliance on Institutionalization. These proposed changes have the very real potential to destroy the most successful community-based, mental health program in the state's history and place more children in institutionalized psychiatric residential treatment facility (PRTF) and residential care. Unbundling the services included in the MYP AC model will put providers in a position of relying on piecing together all of the components of MYPAC through separate service codes for billing purposes; these codes were originally created for services delivered in a community mental health center setting. Unbundling the MYP AC service would require providers to utilize a number of different codes that were never meant to cover a comprehensive in-home service like MYP AC, which includes comprehensive treatment and crisis response, and thus this approach will not sustainably cover the cost of this vital service model.

Repealing MYP AC and/or dramatically revising the MYP AC payment system has the very real possibility of:

- Costing the state of Mississippi and CMS more tax dollars. The repeal, or an ineffective alteration of the payment system can easily eliminate the ability of providers to effectively serve children; and it can disrupt the intensive, in-home services that are at the heart of this successful program, resulting in a sharp increase of institutionalization.
- Denying children an effective service. MYPAC's intensive in-home services not only keeps children out of facilities while they are being served, it has a documented success in altering behaviors and dynamics that lead to repeated needs for services.

MYPAC has a long history of addressing the mental health needs of the state, and Youth Villages stands ready to assist the Division of Medicaid in crafting an appropriate response to concerns raised by CMS, be it in defending this program or helping to reshape or recraft the program.

History

The Mississippi Division of Medicaid developed MYP AC to provide intensive, community-based services to children and families in response to the increased rate of children entering psychiatric care due to the lack of community-based alternatives. Mississippi was one of 10 states to participate in the 1915c demonstration waiver through CMS, and the MYP AC program was recognized as being one of the most successful programs as part of the demonstration waiver. To continue the program's extraordinary success, the Mississippi Division of Medicaid added a MYP AC service definition to the state plan. Since the demonstration ended and it was officially added to the service array in 2012, Mississippi has served thousands of children who would have been placed in a PR TF in their communities through the MYP AC program.

As a MYPAC provider, Youth Villages bas helped over 4,000 youth and families since the program began -spanning both the demonstration waiver and as an official state plan service.

Impacts

We all must recognize that MYP AC services are vital to the state's continuum of care and are cost-effective and clinically successful alternative to young people being placed in PRTF. A comparison of MYP AC costs and benefits must be made to residential level of care and any evaluation based on the benefits of diverting young people from an out-of-home placement. All young people served by MYPAC have such extreme behaviors and psychological needs that a psychiatrist has stated in writing that they need psychiatric inpatient care. Without residential services or an appropriate community-based alternative, these children and youth are a risk to themselves and to others. The intensity of MYPAC services -combining both wraparound facilitation AND therapeutic services -allows it to act as a true diversion from PRTF -level of care. Without MYP AC services, young people will be removed from their homes and placed in long-term residential care.

For example:

- The current MYP AC model and reimbursement structure allows providers the flexibility to do what needs to be done for each family, without concern for covering costs based on billable units. The original intent behind the bundled payment was for providers to have this flexibility to meet each family's needs, as it is difficult, and nearly impossible, to predict the exact set of services and interventions necessary for this diverse population. Though the flexible use of wraparound, case management, and therapeutic services, MYP AC providers can focus on achieving positive outcomes for these youth who are at high risk of PRTF placements.
- If the proposed changes are enacted and the MYP AC rate is unbundled into separate service codes, providers will carry the administrative burden of providing a wide array of services and interventions that each have to be documented and billed separately; this shift will inherently change the focus from achieving outcomes and delivering quality services to billing units that will sustainably cover the cost of the service.

Removing MYPAC from the administrative code removes the only comprehensive community-based service in Mississippi. The number of children in state custody or placed in institutions will rise, and more young people will experience negative outcomes associated with out--of-home placements. Through studies on Adverse Childhood Events (ACEs), science has shown long-term negative impacts on children after being removed from their home. Negative impacts such as mental health issues, physical health issues, and other long-term impacts of childhood trauma are largely avoidable if community-based alternatives are available.

With MYPAC services, the state is purchasing an outcome, not jest a services. Youth Villages' MYPAC program successfully keeps 90% of children in then-home even one-year post-discharge-showing the long-term sustainable impact of MYPAC service delivery. In 2020 alone, Youth Villages maintained nearly 400 youth (who would have otherwise gone to residential placement) in their community for the entirety of the MYP AC treatment.

Not only does MYP AC have strong outcomes in preventing PRTF placement, but MYP AC services speed the transition and reunification process of youth stepping down from residential care. In 2020 alone, Youth Villages safely transitioned nearly 200 young people from acute psychiatric hospitalization and PRTF-level of care back to their communities. MYPAC services not only shortened the length of stay in these residential placements, but also stabilized the youth back in their homes for long-term success. This reduced costs to the state and increased positive outcomes for the children and families served.

The MYPAC program has demonstrated strong outcomes, which are also tied to significant cost savings. In the national evaluation of the CMS demonstration waiver1, evaluators found strong evidence that these community-based alternatives to psychiatric care cost significantly less than paying for residential placements only. In Mississippi alone, savings averaged ~$40,000 per child -a 50% savings over residential costs. Children helped through the waiver program also consistently maintained or improved their functional status. The community-based alternatives to psychiatric care had particularly positive effects on mental health, family functioning and alcohol or other drug use.

This is not unique to Mississippi. Youth Villages delivers intensive in-home services across 13 states, several of which serve the Medicaid population through similar models, with reimbursement structures that allow providers to focus on what is best for kids and families. Youth Villages has decades of experience providing intensive in-home services to children at risk of removal from the home, and currently serves more than 9,000 youth per year in these programs. Outcome data gathered at 6 and 12 months post-discharge illustrates how intensive, in-home services are undeniably extraordinarily effective.

Even in the midst of a global pandemic, Youth Villages has safely served more than 1,000 youth in the community over the past year, keeping these young people connected to their family, schools and community, and out of residential care. The holistic nature of service delivery has been a vital support to youth and families as they continue to navigate challenges related to COVID-19. This means, for example, that families experiencing financial hardships and unemployment have gotten assistance to

stay afloat during the pandemic; this also means that families continue to receive high-quality mental health care in their homes during a time that isolation and stress are increased, which often leads to residual effects such as depression and substance abuse. Without MYP AC services, these young people would be placed in a congregate setting, putting them at increased risk for Covid-19 transmission, and their parents and siblings would also fail to thrive by the removal of one of their key support systems.

Conclusion

The clinical improvements that MYP AC produces for some of the highest risk youth, along with the demonstrated cost-effectiveness of the existing model and reimbursement structure, provides sufficient evidence to continue allowing Mississippi youth and families to benefit from such a successful and cost-saving service.

Youth Villages is prepared to partner with the state of Mississippi to explore solutions to ensure the continuation of the MYP AC program, including helping determine if a Medicaid state plan amendment or a new Medicaid waiver may better ensure that youth can continue to receive effective, community-based services. In the meantime, Youth Villages urges the Division of Medicaid to amend the plan to enact the regulation changes that will disband the MYP AC program as it exists today, so that the hundreds of families currently receiving MYP AC services and the providers who have been working with these families are not left high-and-dry with no plan in place -especially during the COVID-19 pandemic and recovery period.

As a national leader in providing services to children, Youth Villages strongly and respectfully requests the Division of Medicaid to advocate for the preservation of MYP AC. Short of that, we would request the Division work with experienced providers and CMS in crafting an allowable alternative intensive in-home program.

Sincerely,

Pat Lawler, CEO
Youth Villages
3320 Brother Blvd.
Memphis, TN 38133

May 20, 2021

Please find attached our questions/comments re: the recent SPAs distributed by MS Medicaid via email on May 7, 2021. I hope that the data that is included in our response will provide some food for thought during the decision making process re: MYPAC and Wraparound Facilitation service delivery. Thank you for the opportunity to provide this information.

Sincerely,

Mona Gauthier, MS, LPC, MBA
Executive Director
Pine Belt Mental Healthcare Resources
P.O. Box 18679
Hattiesburg, MS 39404

Attachment

System Number 25536. Title 23: Medicaid, Part 223: EPSDT Services, Chapter 1, 2 and 6, Rules 1.3, 1.5, 1.8, 2.5, and 6.1-6.6.

Rule 6.1.A.5. Removal of MYPAC as a reimbursable service: MYPAC is a service that has proven to help children/youth/young adults with an SED diagnosis remain in and increase their abilities to fully live and function within their communities while decreasing the number of hospitalization stays and bed days needed as part of their treatment continuum. The chart below demonstrates the number of youth/families that our agency has served via MYPAC for the past three years, the number of hospital stays and days prior to entering our MYPAC program and the number of Hospital stays and days post admission into our MYPAC program.

Year	Number of MYPAC Youth Enrolled	Number of **Hospital Admits Prior** to MYPAC Admission	Number of **Hospital Admits Post** MYPAC Admission	Number of **Hospital Days Prior** to MYPAC Admission	Number of **Hospital Days Post** MYPAC Admission
2020	41	50	5	825	27
2019	45	70	11	1390	67
2018	84	108	18	1990	242

As you can see, there has been a significant decrease in the need for hospital stays and days for those youth receiving this service, resulting in families and youth having the ability to live within their own communities, lessening the trauma of out of home placements and saving the state money on hospitalization stays/days. It is concerning that a program that has worked so well will be discontinued on such short notice. Wraparound facilitation is the primary component of MYPAC. While the daily rate for MYPAC may seem expensive, it was determined based on all of the services provided for/with MYPAC families and youth and the fact that Wraparound requires an extensive amount of time and expense to carry out with fidelity. Wraparound involves multiple hours of supervision, coaching, formal and informal support team member meetings, crisis planning and intervention, travel, documentation of meetings and services, etc. With the elimination of MYPAC there is no apparent program that will address the needs of youth who pose high risks for safety and mental health well-being.

Should a youth who is currently being served through MYPAC be moved to another program with Prior Authorization requirements, can Medicaid honor the current MYPAC PA that is in place as of June 30, 2021? This will help to decrease any additional barriers to services for these youth and families.

Rule 6.3.E. Wraparound facilitation is part of a targeted case management benefit for EPSDT eligible beneficiaries with a SED that meets the level of care provided in a PRTF. As a component of MYPAC, wraparound facilitation has been typically provided by a BS level staff, under the intense coaching of local and national NWIC coaches/trainers and credentialed by DMH. Two service providers in the state (Pine Belt Mental Healthcare Resources and Choices) have staff that are credentialed by NWIC as National level wraparound coaches and trainers. Wraparound facilitation, as a part of MYPAC, requires prior approval by Medicaid/MCOs/LIPs in order to insure the level of care is warranted. Wraparound facilitators engage a team of formal/informal supports, and utilize the strengths of families, youth, and formal/informal supports/team members to collaborate with the family/youth/team in developing a plan that is strength based, individualized, outcome-based, culturally competent, and driven by family choice, voice and ownership. With the deletion of MYPAC and the inclusion of wraparound facilitation now under TCM, how is this expected to work? TCM has to be performed by staff with at least a MS degree. Is it expected that TCM will be performed by an outside agency, other than CMHCs/current MYPAC/wraparound service providers? Will these TCM individuals be credentialed as Wraparound coaches by NWIC, yet also possess the clinical credentials, successful experience as a provider, and agency capacity necessary to provide comprehensive care? Please consider that introducing another entity into the assessment/treatment process would introduce yet another barrier re: access to care for families and youth who are at the highest risk of hospitalization and out of home placement. Families/youth would be required to tell their stories multiple times, receive duplicative assessments for services and incur a limited choice of providers for care. This would also cause a bottle neck of families/youth being able to receive services on a timely basis in their communities.

System Number: 25525. Title 23; Medicaid, Part 206: Mental Health services, Chapter 1: Community Mental Health Services, Rule 1.1-1.6.

When reviewing covered services, 1.3-B, page 8…could this cover reimbursement for the time it takes to perform assessments? (i.e., CAFAS, DLA20, in the future ASAM, Conners, PHQ9, etc.)?

Please confirm that PCMHT staff are able to perform the same duties as CMHT staff under the supervision of a licensed/credentialed person.

Rule 1.2:E.4.b and 6. Two duties have been eliminated for CSS staff that include working with family members, natural supports. Are CSSs no longer allowed to engage with family members, natural supports, legal guardians, etc. (i.e., for Children and adolescents), etc.? If not, how are needed services supposed to be handled?

Rule 1.3. Q.2. ICORT. ICORT standards require a full time Registered Nurse in order to form a team. In light of the Pandemic, it is extremely difficult to hire/maintain employment for RNs when local hospitals are offering sizeable signing bonuses and high salaries. Will there be any consideration for this in the requirement of a full time RN in order to provide ICORT services? Also, is it expected that ICORT will be the service that can be provided instead of MYPAC? If not, what services will be approved in order to provide intensive services other than/in addition to Wraparound Facilitation to children/youth who have PRTF level of care needs in the community?

Rule 1.4 Non-Covered Services: Lines 1 and 2 have been removed indicating that Medicaid will cover community mental health services that are provided by entities that have not been certified by DMH and who do not meet the standards of DMH. Who are these providers? Do CMHCs no longer have to be certified by DMH?

May 27, 2021

Below are the comments for Region X regarding MYPAC. Thanks.

- Allows children to remain in the home while receiving intensive, residential level of care
- Offers support 24 hours for children and their families
- Helps our families build supports and/or foster more intentional support from people within the community
- Provides our families with an individualized, family driven process that allows our families to feel in control of their treatment, which creates more buy-in and engagement
- Less 'crises' occur
- Crises are handled in real time instead of after they occur
- We have prevented approximately 10 hospitalizations since we started in October

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Russ Andreacchio, MS
Executive Director
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May 28, 2021

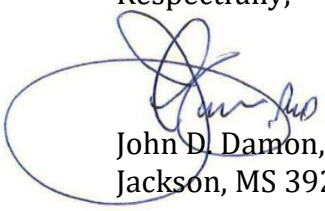
Ms. Margaret Wilson Division of Medicaid Office of Policy
550 High Street, Suite 1000
Jackson, MS 39201
601.359.5248

Subject: Rule: Title 23: Medicaid, Part 223: EPSDT Services, Chapters 1, 2 and 6, Rules 1.3, 1.5, 1.8, 2.5, and 6.1-6.6

Dear Ms. Wilson:

On behalf of Canopy Children's Solutions, I respectfully submit the following Public Comments in advance of the Public Hearing scheduled for June 11, 2021 regarding the proposed rule specified above. Please find below the information required to file this response. We look forward to discussion as we work together to meet the needs of children and families in Mississippi.

Respectfully,



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The proposed changes to Title 23: Medicaid, Part 223: EPSDT Services, Chapters 1, 2, & 6, Rules 1.3, 1.5, 1.8, 2.5, and 6.1-6.6 as set forth in Administrative Procedures Notice Filing submitted on May 5, 2021 are ill-conceived and would have a devastating effect on mental health services for youth in Mississippi. The proposed actions would functionally eliminate MYPAC, the only state-wide, cohesive, comprehensive community-based alternative to deep-end, institutional care. Moreover, the economic impact as set forth in the Notice is misleading and grossly underestimates the financial costs and economic burden to the State should the proposed changes be approved. Namely, the cost estimates incorrectly compare reimbursement costs for MYPAC services (that are, by definition, equivalent to psychiatric residential treatment) to reimbursement costs for to fee-for-service (FFS) out-patient services that lack the intensity and empirical support needed to be a viable alternative to 24-hour psychiatric residential care. In brief, the estimate omits the expenditures of costlier residential, acute hospitalization, and emergency room services that would most certainly result from removing MYPAC as an alternative. Additionally, annual and daily service limits inherent to fee-for-service (FFS) out-patient services would prevent the proposed shift to an *ala carte* reimbursement methodology. In sum, without a repeal or amendment with other viable alternative(s), the proposed changes would end MYPAC, the most successful comprehensive mental health solution for youth in the State's history. That loss, in the middle a pandemic-driven mental health crisis during which the effectiveness and flexibility of those very services are needed most, is a loss that we can ill afford.

Below, we provide a background and historical context for understanding the innovations associated with MYPAC and with the program's positive impact for youths, families, and taxpayers. We submit for consideration numerous (and potentially disastrous) effects of the proposed changes and provide options for alternative courses of action that would not place unnecessary burdens on youths, their families, service providers, and the State.

1. Background
    a. 1915(c) Waiver Demonstration Project. In 2006, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), began an initiative to study community-based alternatives to residential treatment for youths with severe emotional disturbance and their families. The Mississippi Division of Medicaid was among ten grant recipients in the nation, and the state government matched a portion of the funds acquired, bringing the amount allocated to the demonstration project to $66,000,000. The goal of the initiative was to produce evidence that intensive, coordinated, comprehensive community- based psychiatric, mental health, and high-fidelity wraparound services are equally effective and less costly than traditional psychiatric residential treatment.
    b. Historic Award. The 1915(c) waiver approved on October 1, 2007, and the Mississippi Youth Programs Around the Clock (MYPAC) grant of $49.5M over five years awarded on December 19, 2006.
    c. Project Success. In partnership with two not-for-profit providers who remain MYPAC providers today, the Division launched MYPAC on November 1, 2007. Given the careful planning and collaborative efforts of DOM and providers, Mississippi was first in the nation to begin providing services and paying claims. Mississippi had the greatest number of youths served through the first four years of the project. Georgetown University repeatedly featured MYPAC as a state-of- the art innovative example of high quality, cost-effective care. Mississippi officials testified before Congress regarding the effectiveness of MYPAC as a model for other states to emulate. Given the success of the demonstration project, MYPAC was transitioned to a State Plan Amendment in 2012.

2. Impact of MYPAC
    a. Clinical Effectiveness. MYPAC has a distinguished record of success. During the Demonstration project, youths in MYPAC evidenced positive near- and long-term outcomes. Additionally, as a diversion from out-of-home placement in long-term psychiatric residential treatment, MYPAC successfully allowed youths to be served in their communities and allowed youths in residential care to have shorter lengths of stay (as they moved from PRTF to MYPAC). Moreover, use of and fidelity to empirically supported treatments (EST) and evidenced based practices (EBP) is a key component of MYPAC. Any proposed modification to MYPAC should not be undertaken without that solution (or replacement program) meeting the same threshold of demonstrated empirical support.
    b. Cost-Effectiveness. With MYPAC as an alternative to placement in long-term psychiatric care, MYPAC saved the State millions of dollars. The average cost of placing a youth in a PRTF is nearly double that of care in MYPAC[1]. Moreover, prior to the onset of MYPAC, the state faced a consistent rise in the number of PRTF beds through the Mississippi Department of Health Certificate of Need process. MYPAC curtailed bed-expansion.
    c. Robust MYPAC Provider Network and Consumer Choice. The MYPAC Demonstration Project started with two provides and later added a third. As a SPA option, the number of providers has increased dramatically. The addition of each provider increases options for parents and guardian, and Mississippi currently has 17 providers of MYPAC. That robust diversity of choice is critical for parents and does not exist for options for PRTF. Currently, all PRTF (except for CARES Center in Jackson and STF in Gulfport) are owned/operated by national for-profit healthcare corporations that also operate the majority of Mississippi adolescent acute psychiatric hospital beds.
    d. Innovation. MYPAC was brought forth in and accelerated by innovation. Prior to 2007, psychiatric residential treatment level of care in the home was not an option. If youth needed that level of care long-term care, placement in a PRTF was the only choice. MYPAC changed that through a comprehensive (i.e., what is needed), flexible (i.e., when it is needed), community- based (i.e., where it is needed), empirical (i.e., what evidence says works) approach. The advances in high quality care also represented substantial cost savings as care was more local and timely (i.e., it reduced and avoided costlier care in an ER, hospital, or PRTF) and providers were no longer encumbered by burdensome administrative practices (e.g., submitting multiple claims). MYPAC providers were the first in Mississippi (and the nation) to utilize tele-psychiatry services, allowing psychiatric care in hard to reach, rural areas.
3. The Necessity for a Community-Based Alternative To Institutional Care
    a. The High Cost of Deep-End Care. As noted above, the cost of care placing a youth in a PRTF is nearly twice that of the same care provided in MYPAC. However, the true economic cost is almost certainly higher as it does not factor in the near-term increased utilization of acute hospitalization (or crisis residential or partial hospitalization) that would result from eliminating MYPAC. Moreover, given that extant PRTF beds remain at near capacity, waiting lists for admission to PRTFs would skyrocket, additional PRTF beds would need to be brought online, and more youth would be at risk for being placed in PRTFs outside Mississippi in order to meet the need. Additionally, the direct PRTF cost comparison does not account for long-term costs associated with increased risk of entering the juvenile justice system, entering state custody,

[1] Over a 15 month period beginning 1/1/2020, youth served in Canopy's MYPAC program represented potential cost savings of nearly $18.5M versus the cost of placing youth in a PRTF (using the average of published DOM 2020 PRTF rates and assuming both MYPAC and PRTF reached annual maximum limits). The cost of care in PRTF is 192% greater than that of care with MYPAC.

falling behind educationally, and experiencing costly long-term physical health effects that attend untreated or inadequately addressed severe emotional/mental health disorders or adverse childhood experiences (cf., ACEs Study).

b. Increased Risk for Lawsuits to Reduce the Use of Institutionalized Care. The Department of Justice sued Mississippi in 2016 alleging gaps and weaknesses in the state's mental health system that relied too heavily on institutional care by failing to provide sufficient community- based alternatives. The proposed changes impair Mississippi's efforts to exit the ongoing lawsuit by dismantling the only statewide empirically supported community-based alternative for psychiatric residential treatment for youth.

c. Unbundling MYPAC into a Fee for Service (FFS) *Ala Carte* Model Is NOT the Answer. One of the distinct and defining features of MYPAC was (and is) the alternative payment architecture whereby a variety of services were bundled into a single Healthcare Common Procedure Coding System (HCPCS) code with unified prior authorization process. This grouping allowed providers with unique flexibility to focus on outcomes (i.e., delivering those services most needed by beneficiaries to be successful (without being encumbered by the administrative burden of multiple prior authorizations, service caps, daily limits, and claims).

   Furthermore, this bundled architecture included a lock-in feature that forced alignment of service delivery and prevented fragmented (i.e., siloed), duplicative care. When a beneficiary entered MYPAC, all mental health services were coordinated by the MYPAC team. Other mental health providers were unable to provide and bill for services, which reduced redundancy and reinforced collaboration across the provider network.

   Any move to an *ala carte* fee-for-service (FFS) methodology represents a leap *backward* of more than a decade. The standard FFS model was available at the time when MYPAC entered the 1915(c) waiver demonstration project. Had that FFS model been a clinically effective and cost saving alternative to psychiatric residential treatment, MYPAC would not have been necessary. However, service caps, multiple prior authorizations, and limits (daily and annual) inherent to the FFS model prevent the very flexibility and demonstrated outcomes for which MYPAC is known. In a FFS model, many of those services have significant limits such that activities covered in the MYPAC bundled rate (with a single prior authorization) would share common HCPCS and or Current Procedure Terminology (CPT) codes (several of would require a unique prior authorization) with associated maximum allowable quantities. For example, attending IEP meeting and medication management would be billed as Comprehensive Community Support (H2015). Additionally, in a FFS model some services are restricted (i.e., cannot be reimbursed) when provided on the same day, which places the provider in an unfortunate position of choosing between what might be clinically indicated and what is financially practical. See Appendix A for a table that details the variety of services beneficiaries can receive while enrolled in MYPAC.

d. Replacing MYPAC with ICORT Is NOT the Answer. Although both may have a unique role in a comprehensive, community-based system of care, ICORT and MYPAC are distinct and complementary services. MYPAC (with its concentrated, cohesive clinical focus) is the only program specifically designed to deliver psychiatric residential treatment facility (PRTF) level of care for youth. The table below highlights key differences between ICORT and MYPAC.

	Intensive Community Outreach and Recovery Team (ICORT)*	**Mississippi Youth Programs Around the Clock (MYPAC)**
Goal / Purpose	Stabilize the living arrangement, promote reunification or prevent utilization of out-of- home therapeutic resources Has not been used with children and youth.	Community-based alternative to Psychiatric Residential Treatment Facility (PRTF) Intense comprehensive mental health services at the core
Intensity of Services	Not equivalent to PRTF/MYPAC Minimum of 2 visits per week	Equal to PRTF Minimum of 3 visits per week
Evaluation for Admission	Referral from psychiatrist/Nurse Practitioner (NP) NOT required for admission	Evaluation by Psychiatrist/NP and recommendation for MYPAC (PRTF) level of care REQUIRED for admission
Core Team	Requires RN on staff Monthly evaluations by psychiatrist/Nurse Practitioner who is not required to be on core team Peer Support Specialist Full- time member of Team of three	Requires Board Certified/Board Eligible Child psychiatrist on staff Psychiatrist/NP is a member of the Wraparound Team and must see youth within 10 days of admission Full-time Peer Support Specialist is not required
Empirical Support	No data on effectiveness with children and youth. A new program developed following the design of evidence based and fidelity monitored PACT for Adults with Serious Mental Illness. Has not been used with children and youth, so empirical support yet to be established.	Successful implementation of 1915(c) waiver designed for PRTF level of care. Data used to make original State Plan Amendment. Over a decade of evidence of successful outcomes. Requires both EBPs and fidelity monitoring
Staff/Client ratios	1:15	1:5
Use of Wraparound as a Planning Process	Can be provided, but is not required	High Fidelity Wraparound required
Approach to Crisis Management	ICORT and MCERT teams work hand in hand to intervene in crisis. This model has not been used with children and youth.	Proactive (Crisis Plan required within 24 hours of admission). Face-to-face response by MYPAC Team familiar with Crisis Plan.

	Intensive Community Outreach and Recovery Team (ICORT)*	Mississippi Youth Programs Around the Clock (MYPAC)
Use of Peer Support Services	Required for all, but peer is not defined (i.e., individual served or family)	Peer support (focusing on family) as indicated, but not required

*As set forth in the Mississippi Department of Mental Health Minimum Standards.

4. Proposed Solutions to Preserve a True Community-Based Alternative to PRTF
    a. Withdraw Proposed State Plan Amendment(s). To avoid its inherent extensive financial costs and less clinically sound consequences, withdrawing the SPA should be considered as the first course of action. Doing so, resets MYPAC as bundled service in the near-term and allow the Division to work with CMS, DMH, and providers to develop better designed alternatives for submission as a SPA (e.g., with ICORT and MYPAC co-existing, which would strengthen Mississippi's community-based system of care).
    b. Modify Proposed SPA with Wraparound, MYPAC, and ICORT as Distinct Services. As noted earlier, MYPAC is the only solution designed as a community-based alternative to PRTF. Adding the less-intense ICORT while preserving MYPAC would maintain an alternative to PRTF *and* provide a step-down from MYPAC. As a distinct planning process, wraparound can be established as a separate monthly billable service to support the comprehensive community psychiatric/mental health services for youth enrolled in MYPAC or those enrolled in ICORT.
    c. Establish MYPAC under 1915(i) Home and Community Based Service (HCBS) State Plan Service. After the successful 1915(c) waiver demonstration project, MYPAC had two pathways for continuing – State Plan Amendment to the Rehabilitation Option and 1915(i) HCBS SPA. Through extensive work the CMS, the Division successfully used the SPA process to establish MYPAC as an ongoing solution under the Rehabilitation Option of the State Plan. Should the proposed SPA go forward without amendment or modification, one option (albeit costly) would be to continue MYPAC without federal match (i.e., only state dollars) to the keep program operating in its current capacity until a 1915(i) can be secured.

Appendix A
Table 1. Example of Services Provided in MYPAC

Services	MYPAC*	Ala Carte Fee-for-Service** (FFS)	CPT code/daily limit/yearly limit (Additional Qualifier)
Case Management (Community Support)	Included in Per Diem	Limited*** Shared****	H2015/6/400 (15 minutes)
Child and Family Team Meeting	Included in Per Diem	Limited*** Shared****	H2021/16/200 (15 minute)
Crisis Management	Included in Per Diem	Limited*** Restricted*****	H2011/32/224 (15 minute)
DHS Reviewing Hearing (Community Support)	Included in Per Diem	Limited*** Shared****	H2015/6/400 (15 minutes)
Facility Placement (Community support)	Included in Per Diem	Limited*** Shared****	H2015/6/400 (15 minutes)
Family Psychotherapy without Patient Present	Included in Per Diem	Limited*** Shared**** Restricted*****	90846/1/24 (counts with total from 90847)
Family Psychotherapy with Patient Present	Included in Per Diem	Limited*** Shared**** Restricted*****	90847/1/24 (counts with total from 90846)
Family Session Service Facility	Included in Per Diem	Limited*** Shared****	See two codes above (90846, 90847)
IEP Meeting (Community Support)	Included in Per Diem	Limited*** Shared****	H2015/6/400 (15 minutes)
Individual Psychotherapy	Included in Per Diem	Limited*** Shared**** Restricted*****	90832,90834,90837/1/36
Intake Psychosocial Assessment	Included in Per Diem	Limited*** Restricted*****	90791/1/4
Medication Management	Included in Per Diem	Limited*** Shared****	99211,99212,99213, 99214, 99215/ 2 for all but 99211 and 99215-1/ 12 yearly
Medication Monitoring (community support)	Included in Per Diem	Limited*** Shared****	H2015/6/400 (15 minutes)
Office or Other Outpatient Service – Established Patient	Included in Per Diem	Limited*** Shared**** Restricted*****	99211,99212,99213, 99214, 99215/ 2 for all but 99211 and 99215-1/ 12 yearly
Office or Other Outpatient Service – New Patient	Included in Per Diem	Limited*** Shared**** Restricted*****	99202,99203,99204, 99205/1/1(counts against above yearly limit too)
Peer Support Services	Included in Per Diem	Limited***	H0038/6/200 (15 minutes)

Services	MYPAC*	Ala Carte Fee-for-Service** (FFS)	CPT code/daily limit/yearly limit (Additional Qualifier)
Psychiatric Evaluation	Included in Per Diem	Limited*** Shared**** Restricted*****	90792/1/4 (counts against yearly total below and with 90791)
Psychiatric Review	Included in Per Diem	Limited*** Shared**** Restricted*****	90792/1/4 (counts against yearly total above and with 90791)
Wrap Around Team	Included in Per Diem	Limited*** Shared****	H2021/16/200 (15 minute)
Wrap Around Individual	Included in Per Diem	Limited*** Shared****	H2021/16/200 (15 minute)
Wrap Around Family	Included in Per Diem	Limited*** Shared****	H2021/16/200 (15 minute)

*Included in MYPAC per diem bundle (up to 115 units in 270 days).
**As determined by Division of Medicaid Fee Schedule.
***Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes have daily and/or annual maximum allowable quantities that are lower than that of MYPAC.
****Activities covered in MYPAC bundled rate would have a common HCPCS code with associated maximum allowable quantities. For example, attending IEP meeting and medication management would be billed as Comprehensive Community Support (H2015).
***** Healthcare Common Procedure Coding System (HCPCS) and/or Current Procedural Terminology (CPT) codes cannot occur on the same day as other fee for service activities/codes.

May 28, 2021

I just saw in a blog that Medicaid is proposing policy changes to MYPAC that will remove MYPAC coverage and reimbursement. As a MYPAC provider, I was disappointed to hear the news and even more disappointed to find out in a blog. Perhaps a better alternative would have been to invite MYPAC providers to help assess the value of this service.

Mississippi is the poorest state in the United States. Mississippi's child poverty rate is the highest in America. Of the 721,288 children living in Mississippi, 30% of them are poor. One in five children in the United States has a diagnosable mental disorder lasting a year or longer. From my experience, those numbers move to one in four in the state of Mississippi. MYPAC was created as an alternative to help children avoid possible placement in long term psychiatric residential treatment facilities and instead provide treatment for them in their homes, schools, and communities. It also was found to be beneficial for children coming out of residential treatment centers, therefore reducing the number of readmissions.

The proposed changes stand to increase the number of children being placed in long term psychiatric residential facilities with the number of times a child is placed in long term psychiatric residential facilities also likely increasing. Is that what we really want for our children? Do we now want our children who have severe treatable mental health diagnoses to receive mental health services in institutions rather than in their homes, schools, and communities?

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Region 6 has serious concerns regarding the Division's intent to abruptly eliminate MYPAC from the array of services designed to treat the most at-risk youth in our state. For approximately 14 years, the MYPAC program has been incredibly effective in reducing the admission rates to Psychiatric Residential Treatment Facilities (PRTFs), much in the same way that the Program of Assertive Community (PACT) program has been effective in the adult arena in reducing revolving-door admissions to the state psychiatric institutions. At Region 6, the MYPAC program has been 100% effective in diverting children and youth from placement at a PRTF. Additionally, the program has dramatically reduced the number of hospital bed days by nearly 70 percent. Elimination of the most successful intensive, community-based program available to children and youth with the most complex serious emotional disturbances, with no suitable alternative, will undoubtedly place the state in continued jeopardy with the Department of Justice.

To date, there has not been clear guidance as to how the Division intends to reimburse and support Wrap-Around Facilitation as a stand-alone service. Wrap-Around Facilitation is an extremely labor intensive service that is not sustainable under the current rate of reimbursement of $14.88 per unit. It is important to also note that, to be reimbursable as a stand-alone service, the activity must be conducted face-to-face. However, there are numerous mandatory non face-to-face service requirements to include: assembling the child and family team, creation of the plan of care and monthly updating to that plan of care, working with the team in identifying providers of services, linking the child and family to various community resources, copious documentation requirements, weekly collateral contacts with team members or other key supports and other care coordination activities. In addition to these mandatory non-billable activities, all wrap-around facilitators and their supervisors are required to participate in ongoing coaching and training sessions that are very time consuming. Staff are also expected to be available 24/7 to respond to mental health emergencies that may arise. Travel and transportation time is another non-billable activity. Furthermore, unbundling Wrap-around Facilitation will limit the service to 100 units per year and a max of 8 units per day. Such service limitations will not allow providers to carry out the service with the degree of intensity needed to match the needs of children and youth served in MYPAC. When unbundled, same day service exclusions further erode a provider's ability to be responsive to the needs of the child and family. Daily and annual service caps, coupled with mandatory non-billable activities, ultimately create an environment that discourages agencies from providing the service and/or an environment in which fidelity to the model is unattainable. Discouraging providers from continuing to provide Wrap-Around

Facilitation is short-sighted in that these high risk children will be served in other costly services, such as ERs, psychiatric hospitals and PRTFs.
