RCPA CAP Report
April 2024

REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

2024/25 Budget: Mental Health Program Recommendations:

This budget recommends the following changes: (Dollar Amounts in Thousands) for Mental Health Services

- $20,000 — To replace nonrecurring prior-year carryover funding.
- $5,750 — Initiative to expand diversion and discharge for individuals with mental illness currently in the criminal justice system.
- $18,259 — To continue current programs.
- $20,000 — To restore one-third of base funding to counties.
- $3,443 — To replace federal funding received in 2023/24.
- $5,000 — Initiative to maintain walk-in mental health crisis for COVID-19 response stabilization centers serving multiple counties.
- $1,250 — To annualize prior-year expansion of home and community-based services.
- $1,600 — Initiative to provide home and community-based services for 20 individuals currently residing in state hospitals.
- $305 — To annualize prior-year expansion of diversion state hospitals and discharge programs.
- $10,000 — Initiative to provide support to the 988 network for mental health services.
- $85,607 — To increase appropriations.

School-Based Mental Health

This year, the Shapiro Administration looks once more to address the needs of student mental health with a $100 million investment. This new set of funds comes on the heels of $90 million recently allocated to schools, with monies originally set aside for adult mental health services targeted through the now defunct 2022 Behavioral Health Commission.

RCPA provided testimony to The House Education Committee held hearings over two days to gather testimony and recommendations regarding student mental health in schools. Included in the panels was RCPA Policy Director Jim Sharp, who testified regarding creating viable student mental health programming, including revitalizing the Student Assistance Programs (SAP) that build upon continued relationships and expertise of the community-based mental health providers. RCPA also outlined sustainable allocation strategies to ensure funding be directed to the school districts and the development of a large-scale, statewide mental health strategy. View our testimony here.

Early Intervention Services

As part of our initial budget discussions with OCDEL, we were concerned that there would not be an interim rate increase for 2024/25 as we work through the new Early Intervention rate methodology. We see in the budget that there is an increase of $16 million, nearly 9% over last year's number. It is also projected that more children and families will be served in this coming year, and we will work with the administration to, at a minimum, continue to fund the ARPA-supported 3% increase from over the last three years.

County Child Welfare

It is projected that the County Child Welfare budget will essentially be flat, with less than a 1% increase. As the child welfare systems await the DHS Blueprint recommendations on addressing the extensive number of services for youth with complex care, especially those in congregate care, it was surprising there was not a designated funding allocation to support this initiative. This remains a priority to fund these programs.

County-Based Mental Health Funding

It was disappointing that the Shapiro Administration failed to deliver on last year's "down payment" of the 2022/23 allocation of $20 million towards the county base. Up until last year, the county-based mental health system has gone more than a decade without a base rate increase. Last year's $20 million represented only a 3% increase over the 2022/23 base funding. This year's $20 million will equate to less.

We will continue, as part of our advocacy strategy, to support an allocation that is projected to be in the neighborhood of $1.2 billion to create a sustainable platform for county-based mental health service delivery.

- **RCPA BH Coalition**

We are reviewing internally a new advocacy approach that expands in some areas a broader mental health funding strategy than the MHSN coalition that solely focused on county based adult MH funding

RCPA Mental Health Funding Priorities and Legislation

Across RCPA Divisions

- Workforce initiatives and funding
- DSPs, DCWs, counselors, case managers, peers, and licensed staff

- Regulatory reform: Decreasing administrative burden; reducing barriers to access for care
- Advocate for funding that reflects true “cost-plus” and for meaningful, transparent, VBP models

Behavioral Health (adult and children’s mental health; substance use disorder services)

- $100M in adult mental health services; $60M in continued investment for county-based MH funding
- $100M in school-based mental health funding supporting collaborative school/community-based treatment
- Support for re-implementation of the national CCBHC model and funding
- Focus on parity and integrated behavioral and physical health care model
- Address redundancy and inconsistency among substance use disorder treatment audits and overseers
- Enhance access to methadone for opioid use disorder and improve treatment models within program.
- Ensure the sustainability and integrity of the Opioid Use Disorder Centers of Excellence (COE) program
- Amend the IBHS regulations to address access issues, and payment equity between IBHS / ABA services
- Resolve the CMS 4 Walls telehealth barriers issues to expand delivery pathways
- Ensure Medicare enrollment for clinicians recognizes completion of the 3000 supervision hours as PA licensing standards

A. CMS Medicare Enrollment

Medicare Enrollment Update:
Supervision Hours Documentation Available

As part of RCPA’s ongoing efforts to assist members in the CMS Medicare enrollment process, we have worked with the Bureau of Professional & Occupational Affairs State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors to create a path for individuals with professional licensure to access the documentation of their supervision hours, which were a part of the original licensure approval. The following Request for Verification of Supervised Clinical Experience form can be completed and submitted along with a processing fee. This documentation can be submitted to CMS/Novitas Solutions for those enrollment applications that have been rejected. We have confirmed that this form would satisfy the requirements of the enrollment standard, and the results will now be emailed to the applicant to expedite the request.

RCPA does not have a timeframe for request processing, but we have reached out to CMS/Novitas Solutions to see if they would take into consideration this additional step to ensure applicants have the time to submit the required supervision hour(s) documentation while the enrollment application remains in open status.

Novitas Solution is also now permitting the documentation on Company letter head providing an attestation that the clinician has completed the 3000 hours of supervision.

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B. Telehealth Update

OMHSAS and the Federal 4 Walls

Federal "4 walls" statute, this is a required Federal Medicaid payment condition. These requirements cannot be waived.

During this time, RCPA will continue its efforts and work with OMHSAS, the HealthChoices partners, and stakeholders to ensure access to services via telehealth. You can review today's OMHSAS telehealth webinar slide deck. We are also looking to obtain a recording of the webinar to share with our members.

In response to the recent developments on the delivery of telehealth services and its intersection with Federal Medicaid payment standards outlined in the "4 walls" requirements, RCPA has widened its efforts in addressing the barriers currently in place. It has been determined that the most effective route to address this would be through legislation. The necessary changes cannot be achieved through a revised Tele-Behavioral Health Bulletin.

We are hopeful for an expedited legislative solution that will support OMHSAS in making any resulting policy, practice, or programmatic changes that will support the initiative. RCPA continues, for providers to be patient, review your contingency plans, and focus

Co-Sponsorship Memo in both the house and the senate finalizing language and additional support in the house and senate. Ongoing meetings with OMHSAS and DHS legal.

Lastly, RCPA continues its dialogue with OMHSAS for guidance and clarification, including sharing members' and stakeholders' feedback. We have had the opportunity to speak with our BH-MCO members and understand OMHSAS Deputy Secretary Jen Smith will be meeting with that group and the county contractors on the processes moving forward.

OMHSAS did conduct another Telehealth forum in mid-march to confirm the process and to get additional feedback form Providers. Lastly Jen Smith did provide support for providers continuing their efforts to ensure clients get services

Federal Telehealth

Pending Legislation (Live Links)

- **H.R. 134**, *To amend title XVIII of the Social Security Act to remove geographic requirements and expand originating sites for telehealth services* (Reps. Vern Buchanan and Michelle Steel)
- **H.R. 1110**, *KEEP Telehealth Options Act of 2023* (Reps. Troy Balderson, Susie Lee, Ashley Hinson, and Joe Neguse)
- **H.R. 3432**, *Telemental Health Care Access Act* (Rep. Doris Matsui)
- **H.R. 3875**, *Expanded Telehealth Access Act* (Reps. Mikie Sherrill, Diana Harshbarger, Lisa Blunt Rochester, Andre Carson, David Valadao, Jennifer Kiggans, Mark Pocan, Glenn Thompson,

Tracey Mann, Chellie Pingree, Salud Carbajal, Marc Veasey, Marie Gluesenkamp Perez, Susan Wild, Greg Stanton, Don Bacon, Colin Allred, and Josh Gottheimer)

- **H.R. 4189**, *CONNECT for Health Act of 2023* (Reps. Mike Thompson, David Schweikert, Doris Matsui)
- **H.R. 5541**, *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* (Reps. Robert Latta and Debbie Dingell)
- **H.R. 5611**, *Helping Ensure Access to Local TeleHealth (HEALTH) Act of 2023* (Reps. Glenn Thompson and Ann Kuster)
- **H.R. 6033**, *Supporting Patient Education And Knowledge (SPEAK) Act of 2023* (Reps. Michelle Steel, Jimmy Gomez, Juan Ciscomani, Adriano Espaillat, Tony Cardenas, Monica De La Cruz, Young Kim, Henry Cuellar, Judy Chu, Jimmy Panetta, David Valadao, Juan Vargas, Salud Carbajal, Susie Lee, and Terri Sewell)
- **H.R. 7149**, *Equal Access to Specialty Care Everywhere (EASE) Act of 2024* (Reps. Michelle Steel, Susie Lee, Mike Kelly, Darrin LaHood, Donald Davis, Yadira Caraveo, Lori Chavez-DeRemer, Don Bacon, Monica De La Cruz, Andrea Salinas, and David Valadao)
- **H.R. 7623**, *The Telehealth Modernization Act of 2024* (Reps. Earl "Buddy" Carter, Lisa Blunt Rochester, Gregory Steube, Terri Sewell, Miller-Meeks, Debbie Dingell, Jefferson Van Drew, and Joseph Morelle)
- **H.R. 7711**, *To amend title XVIII of the Social Security Act to make permanent certain telehealth flexibilities under the Medicare program* (Reps. Debbie Dingell, and Jack Bergman)
- **H.R. 7858**, *Telehealth Enhancement for Mental Health Act of 2024* (Reps. John James, Donald Davis, and David Schweikert)
- **H.R. 7856**, *The PREVENT DIABETES Act* (Reps. Diana DeGette, Gus Bilirakis, and Jason Crow)
- **H.R. 7863**, *To require the Secretary of Health and Human Services to issue guidance on furnishing behavioral health services via telehealth to individuals with limited English proficiency under Medicare program* (Reps. Michelle Steel, Gus Bilirakis and Susie Lee)
- **H.R. ____**, *Hospital Inpatient Services Modernization Act* (Reps. Brad Wenstrup and Earl Blumenauer)

CMS Updates FQHC, RHC and Mental Health MLN Booklets

In mid-March, the Centers for Medicare and Medicaid Services (CMS) announced that they had updated their Medicare Learning Network (MLN) booklets for federally qualified health centers (FQHCs), rural health clinics (RHCs) and mental health services. The Medicare MLN booklets explain national Medicare policies on coverage, billing and payment rules for specific provider types. The telehealth related changes incorporate the extensions to pandemic telehealth flexibilities made by the Consolidated Appropriations Act, 2023, as well as changes to policy that were made in the 2024 Final Physician Fee Schedule. The major telehealth changes for each manual are noted below.

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C. OIG Federal Medicaid/Medicare Report

Lack of BH Providers in Medicare and Medicaid Impedes Enrollees' Access to Care

The Office of the Inspector General (OIG) has released a report citing there are not enough behavioral health providers participating in Medicare and Medicaid networks.

In an analysis published April 2, the government watchdog studied one urban and one rural county in 10 states across the country. The analysis found relatively few behavioral health providers are participating in Medicaid, Medicare and Medicare Advantage programs, leading to difficulties in access for enrollees.

Notable Findings:

1. On average, there were fewer than five active behavioral health providers accepting Medicare and Medicaid patients per 1,000 enrollees. Traditional Medicare had the lowest rates of providers, at 2.9 per 1,000 on average, and Medicare Advantage had the highest rate at 4.7 per 1,000 enrollees.

2. Rural counties had fewer providers accepting Medicare and Medicaid than urban counties. In rural counties, there were 1.5 providers accepting traditional Medicare per 1,000 patients, compared to 4.4 in urban counties.

3. Across Medicaid, traditional Medicare and Medicare Advantage, there were fewer than two providers per 1,000 enrollees that could prescribe medication for mental health issues, such as psychiatrists and psychiatric nurse practitioners.

4. Active providers accepting public insurance make up around one-third of the behavioral health workforce, according to the report.

5. Fewer than 10% of public insurance beneficiaries received mental health treatment in 2023.

6. CMS could also tighten network adequacy standards in Medicare Advantage and Medicaid to increase the size of insurers networks, the OIG said in its report.

7. The OIG recommended CMS up its oversight of Medicaid and Medicare enrollees' use of behavioral health services and recommended CMS examine allowing more types of behavioral health providers to participate in Medicare and Medicaid.

8. CMS said it concurred with the OIG's recommendations and said it has already taken several steps to improve access to behavioral health providers for Medicare and Medicaid beneficiaries.

Members may view the full report here.

D. National Council Hill Day June 5 & 6

Hill Day 2024: June 5-6, 2024 - Register Now!

Have you reserved your spot to advocate with us in Washington, D.C., June 5-6, 2024?

Space is filling up fast for our first in-person Hill Day in five years, and we'd love to see you there - don't miss your chance!

REGISTER NOW!

This is a great opportunity to sit down face to face with your elected officials and their staff to share your stories, as well as those of your organizations and the people you serve.

Hearing directly from you, their constituents, is invaluable to convincing them to prioritize our collective policy solutions. With a greater understanding of their communities' needs and your ideas for shaping the future, they can take the necessary action to help us get there.

Join us in June, and together, we'll share solutions and urge our elected officials to support key mental health and substance use care initiatives that expand access to care and bolster the workforce.

- Have questions about registration, travel, lodging or event logistics? Contact the Events Team.
- Have questions about the Public Policy Institute, Capitol Hill visits or legislative asks? Contact the Policy Team.

BH Council / BH Council Advisory Group

The governor's BH Advisory Committee has met 2three times to date and it remains a very broad and big picture view. The discussion is also to include ALL of BH. Not just Medicaid and Medicare, but commercial insurance, self-pay, indigent care, etc. So it is a lot to tackle.

As with most task forces and groups, the real issue will ultimately be the impact. If we recommend something to the governor or his office- what does that mean? What would then happen? RVPA President and CEO represents RCPA on the Advisory Committee

CCBHC Update

As part of RCPA participation in the national initiative for the Delta Center for a thriving safety net. The National Council is deeply partnered in this work and had the opportunity to meet with them and the Delta Center Convening in Louisiana last week. Jeff Delia Policy Analyst the Council presented the most up to date developments on the CCBHC

See the attached PowerPoint presentation

Announcing a new CCBHC State Technical Assistance Center

The National Council was recently awarded a multi-million-dollar contract from the Substance Abuse and Mental Health Services Administration (SAMHSA) to create a new Certified Community Behavioral Health Clinic State Technical Assistance Center (CCBHC STAC). This federal contract will broaden our capability to help states develop and implement CCBHCs, a model of care that makes mental health and substance use treatment accessible to everyone, regardless of their diagnosis and insurance status. This new technical assistance center will build on our current work supporting CCBHCs, allowing us to expand their successful implementation nationwide. Stay tuned for more details!

Federal CCBHC PPS Overview

As Pennsylvania reviews reentry into the CCBHC the Prospective Payment System remains a critical area of consideration. The following provides an overview of the 4 PPS options

- *PPS*

  CCBHCs are statutorily required to offer nine services: (1) crisis mental health services; (2) screening, assessment, and diagnosis; (3) person-centered treatment planning; (4) outpatient mental health and substance use services; (5) outpatient clinic primary care screening and monitoring; (6) targeted case management (TCM); (7) psychiatric rehabilitation services; (8) peer support, counselor services, and family supports; and (9) intensive, community-based mental health care for members of the armed forces and veterans. The statute requires the use of a prospective payment system (PPS) methodology to pay participating clinics for the provision of the nine statutory services and requires the Centers for Medicare & Medicaid Services (CMS) to issue Guidance to states and clinics on the development of the PPS to be used Demonstration-wide. The CCBHC PPS applies to services delivered either directly by a CCBHC or through a formal relationship between a CCBHC and Designated Collaborating Organizations (DCOs), as that term is defined in the Substance Abuse and Mental Health Services Administration (SAMHSA)-developed CCBHC Criteria.

  CMS developed the PPS Technical Guidance ("the Guidance") for CCBHC payment considering the CCBHC Criteria established by SAMHSA with regard to the six statutory program requirements developed for 1) staffing; 2) availability and accessibility of services; 3) care coordination; 4) scope of services; 5) quality and other reporting; and 6) organizational authority and governance.

  The first option, Certified Clinic Prospective Payment System 1 (CC PPS-1), is a Federally Qualified Health Center (FQHC) like PPS rate that provides reimbursement of the expected cost of providing CCBHC services on a daily basis with the state's option to provide QBPs to CCBHCs that meet quality measure performance thresholds established by the state. QBPs for CC PPS-1 are not required and changes to the QBP program should not be seen as changing the underlying PPS system.

  The second option, CC PPS 2 (CC PPS-2), provides reimbursement of the expected cost of providing CCBHC services on a monthly basis and allows states the option to develop separate Special Population (SP) rates to cover the high cost of individuals with certain clinical conditions. Additionally, the state is required to incorporate QBPs and outlier payments as part of the CC PPS-2 methodology.

  The third option, CC PPS 3 (CC PPS-3), provides reimbursement of the expected cost of providing CCBHC services on a daily basis. While CC PPS-3 mirrors CC PPS-1 with the requirement to set clinic-specific daily PPS rates and optional QBPs for CCBHCs that meet 3 state-defined quality metric thresholds for payment, it also includes the newly required daily Special Crisis Services (SCS) rates, which allows states to set separate PPS rates for crisis services provided by CCBHCs. SCS rates may be set for one or more of the following categories of crisis services: 1) mobile crisis services that meet the criteria for being qualifying community-based mobile crisis intervention services as authorized under section 9813 of the American Rescue Plan Act of 2021 (P.L. 117-2, ARP), 2) mobile crisis services that do not meet the qualifying criteria of ARP section 9813, and 3) on-site crisis stabilization services.

The fourth option, CC PPS 4 (CC PPS-4), is similar to CC PPS-2 in that it also has a monthly unit of payment, required outlier payments, and required QBPs for CCBHCs that meet state defined quality metric thresholds for payment, and optional SP rates for people with certain conditions. In addition to these elements, CC PPS-4 also requires the new separate monthly SCS rates similar to those required under the CC PPS-3 methodology.
Applicable Federal Medical Assistance Percentage (FMAP) Rates
PAMA permits states to claim expenditures related to payments made for CCBHC services at the enhanced Federal Medical Assistance Percentage (FMAP)

For more information please go to : **CCBHC PPS Guidance Proposed Updates - Medicaid.gov**

OMHSAS ICWC Updates

- OMHSS is awaiting response from SAMHSA on their questions for reentering the CCBHC Demonstrations Project
- Several key inquiry areas include the Proposed Payment System. The transition of current ICWCs back to the demonstration, timelines to do so, requirements for the implementation of new CCBHC Criteria from 2023

- In the event Pa does return to the CCBHC demo It is unclear how the programs will reintegrate and under what category they will fall for critical areas such as
  - Funding
  - Supervision
  - Categorical service model

- RCPA has inquired if PA. did not renter the demonstration project then consideration and funding be developed no for an ICWC expansion in 24-25 or 25-26

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- What in preparation of a decision I wanted to take few minutes to get the groups insights on two strategic areas around re-entry into the demonstration or the expansion of ICWCs as we move forward
- With our understanding of the redesign for the CCBHC and the possibility of transitioning the ICWCs back what are key considerations, practice, factors you feel are priorities to implementation.

CCBHC/ ICWC
- Who gets first consideration
- Expected expansion ICWS +plus
- Funding for planning grants?
- Time frame
- Metrics
- Program ramp up with new criteria
- Funding scheme
- Training
- Technical assistance

A review of the budget did not hint at any major changes in the 24-25 budget so I think it is safe this would appear in the 25-26 budget / Calendar 25 operating years

Resources

SAMHSA's National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit, which includes minimum standards for the coordination of crisis services, mobile crisis response, and crisis stabilization.

National Council on Mental Wellbeing CCBHC CCBHC - National Council for Mental Wellbeing (thenationalcouncil.org)

I. Legislative Updates

A. RCPA School-Based Mental Health House Education Committee

Building upon Governor Wolf's legacy investment of $100 million for school-based mental health services in his final budget, Governor Shapiro as well has committed $100 million dollars a year over the next 4 years. This in addition to this year's $100 million in ARPA funds. These significant dollars will provide the building blocks in creating one part of a sustainable mental health continuum of care. For that to happen, there are several considerations.

- *With the first and foremost being that the school districts partner with the community-based mental health providers to build a system of services delivered by the most qualified, most highly trained, certified and licensed staff in the state.*

- *Second, the utilization and flexibility of these funds to be utilized by the schools to meet the diverse needs of the students and communities in building programming not infrastructure*
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- *And lastly, RCPA and many others agree that the distribution formula and allocation of the funds directly distributed to school districts through a grant process has proven effective in delivering these funds in an equitable and efficient manner.*
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- *These outlined strategies would build on the existing relationships between the schools and the community provider network for partnership and collaboration in planning, developing, and implementing the delivery of quality treatment and service.*

We must avoid the scenario whereby we build a "secondary" mental health system in the school, and one in the community, as there is not the time, expertise, or workforce that could accommodate or sustain two separate service delivery entities.

As it relates to this, there are many proponents supporting the idea of putting a social worker in every school, and while in practice this may seem like a thoughtful alternative, I urge decision makers to consider that for a district to hire one social worker, the following will occur:
• Up to 40% of every dollar will go to benefits, fringe, retirement, etc.
• A social worker in the school builds infrastructure, not service to students in need.
• These positions do not work year round, leaving students unattended during the summer months.

• No history of long-term funding to guarantee jobs.
• The current clinical workforce could not support two mental health systems – one in the school and the other in the community – the competing systems would cannibalize themselves.

Recommendations

• The need to coordinate community-based and school-based mental health services is the key to building a sustainable footprint of mental health in our schools.
• Through collaboration and planning, these entities can plan, design, and implement strategies that meet the needs of their student's population and community.
• Invest funding into rebuilding the Student Assistance Programs in the schools. They are mandated and yet underutilized and outdated. This is the first line of defense to addressing student mental health.
• Create a system that supports the continuity of care for children and families where they live and attend school.
• Build mental health programming; not mental health infrastructure.
• Dedicate funds to training school staff on adolescent behavioral health through mental health first aid and youth/teen mental health first aid.

Telehealth Legislation

RCPA continues its efforts with the Office of Mental Health and Substance Abuse Services (OMHSAS) on Medicaid payment condition under the Federal "4 walls" statute,

The purpose of today's call was twofold: explaining the "4 walls" requirements, and for providers to give vital feedback to OMHSAS on the impacts, challenges, and barriers to accessing services that this may create for consumers and families. The legislative fix will address the payment and treatment conditions of the 4 Walls by moving telehealth under the rehab option of mobile mental health in accordance with the OHSAS Chapter 5200 Outpatient regulation

RCPA has continues to work the Executive Directors of the House Human Services Committee to fine tune the language in anticipation of the final version. We have also secured a co-sponsorship memorandum from a Senator's Culvers office and expect a Co-Prime Sponsor in the House to join Tina Pickett's Sponsorship It has been determined the vehicle for this will be to amend our current draft legislation that initially was created to address the psychiatrist in-office time requirement.

It has been determined that this legislation would also address the long standing issue on the required psychiatric time for outpatient clinics. Act 76 the current law did not go far enough in addressing the issue despite efforts from RCPA to include this in the original bill. This version will allow for the use of advanced practice professionals or psychiatrist to fulfill the required in clinic time mandates. Additionally, the language will allow either of these professional positons to provide required supervision either face to face or via telehealth.

Regulatory Reform

A. Current Status of Pending Regulations Reform: Next Steps with OMHSAS

RCPA has submitted to the Pa General Assembly Executive Directors in both the House and Senate, The governors Policy Office, DHS Secretary Arkoosh as well as each respective DHS Deputy Secretary a set of Regulatory Reform guidelines and recommendations for each respective policy divisions.

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Included in the recommendation:

- The intersects between regulatory burdens from an administrative perspective and its impact on the lack of access to treatment and the workforce crisis
  A review of regulatory standards around staffing qualifications, training requirements rand auditing process for licensing, BH MCO and County entities should be a priority
- Change to the regulatory process whereby DHS legal reviews the regulations for years before it even goes to the governor is one feel needs to be examined. This process yielded little to no progress of regulations at DHS

Regulations Submitted to DHS for consideration and review
Children's
IBHS
Family Based
Early Intervention (OCDEL)

Adult MH
Outpatient
ACT
CRR
LTSR

Regulation Release Update

OMHSAS is preparing for the final review for the Crisis and PRTF Regulations anticipated to be released in 2024