CONFERENCE OF ALLEGHENY PROVIDERS

CAP Meeting Minutes
April 12, 2024

Welcome and Introductions
Sue Coyle, CAP President, called the meeting to order at 1pm. She welcomed everyone to the meeting.

Review / Acceptance of Minutes
Review and acceptance of the March 2024 meeting minutes: Minutes were sent out via email to the group and posted on the CAP website for review. A motion was given by Kim Sonafelt and a second was received by Chris Zellefrow to accept the minutes as presented.

Treasure's Report –Tom Cloherty
Present balance: $70,968.79
If anyone has expenses for Capital Day, please send them in for reimbursement.

RCPA updates- Jim Sharp

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.

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.

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**

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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
- 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)

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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*
- *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.*
- *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.

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.

Legislative Affairs Committee- Gretchen Kelly
4/12/2024

1. RCPA Capitol Day Re-cap 3/19/24
    a. Thanks to Step by Step, Citizen Care, and Emmaus Communities for representing CAP at the Rally
    b. Rally was successful and the largest group of legislators to date included:
        i. Rep. Stephen Kinsey, co-chair, Health and Human Services Committee
        ii. Rep. Doyle Heffley, co-chair, Health and Human Services Committee
        iii. Rep. Dan Miller
        iv. Rep. Frank Farry
        v. Sen. Art Haywood, co-chair, Health and Human Services Committee
    c. Connections made with staff members of Rep. Kinsey with plans for follow-up.
    d. Don't forget to turn in mileage and tolls via Tom Cloherty
2. Meeting with Gov. Shapiro Staff 3/20/24
    a. Meghna Patel, Dep. Sec. of Policy/Planning

   b. Lindsay Mauldin, Dep. Chief of Staff
   c. Dr. Christina Finello, Executive Directo, BH Council
   d. Discussed shift in funding from Community BH to Schools
   e. Discussed Regulation Reform and follow-up requested.
3. Dan Miller Disability Summit 4/18-19, 2024
   a. Legislative Panel 4/19 to discuss Workforce Issues specific to BH programs.
      i. CAP represented on the panel and documents highlighting workforce issues across the human services sector to be distributed.
   b. Governor Shapiro to attend the Summit on Thursday
   c. Allegheny County Exec. Innamorato to attend on Friday.
4. MHA of SW PA to host Legislative Breakfast 5/10/24.
   a. CAP Representation on panel.

IDD Committee- Denise Cavenaugh

The IDD Committee did not meet in April.

Behavioral Health Committee- Heather Harbert

Friday, April 12, 2024
10:30a-11:30a

1. Welcome and Introductions
2. Items for Discussion:
   a. RCPA Update- Jim unable to attend this month
   b. Open discussion:
      i. Team brought up difficulties with staff retention and paying for psychiatric services
         1. keep clinic licensed and moving toward private practice model?
      ii. Expenses continue to climb with the rising cost of locums
      iii. Losing therapists to private practice at rates we cannot compete with
      iv. Discussion of building other programs to offset but that's not covering
      v. Use of AI as options for retention help
   c. CRR discussion and updates
      i. Meeting with county to discuss, involvement of stakeholders, need to be at the table, part of decision making
      ii. State present at that meeting, articulated that the county has responsibility and authority over the use of the base money
      iii. Providers continue to express worry and concern

iv. There is a possibility of many CRRs having to close, want/need for 24/7 staffing
v. Are APAs or other models of pay possible?

Next Meeting: 5/10/24

DEI Committee- Nora Soule
Meeting Date: 11:00am-12:00pm, April 11th, 2024

Next Meeting Date: 5/9/24

Participants : Nora Soule, Meg Sova, Jesse Mclean, Fred Mbewe, Shelli Flemming, Rachel Kyles, Andrea Brown, Dave Zarlengo

Agenda Items	Discussion	Action Needed
Welcome/ Introductions		
Summary of Purpose	**The CAP Equity Committee will intensify awareness of and advocate for racial equity and social justice for historically marginalized individuals through education, research, and leadership development; allowing for the intrinsic value of all individuals to be recognized.**	
Standing Topics	• Agency updates	
Book Club Discussion	Let's Protect Our Frontline Workers from Rude Customers (hbr.org) • Sharing media club information with other organizations	If you are comfortable, please share an example you've experienced or witnessed of a difficult interaction with a customer/client/patient. What was the outcome? Christine mentions that her survey results reflect there is more of an issue with customer interactions in healthcare. Since we all work for organizations that could at least be considered healthcare adjacent, why do you think that is? Is there anything

		we can take away from this observation that can be used to support our front facing employees? Christine talks about several reasons for rude behavior in the workplace, which reason stood out to you the most or struck you as the most concerning? Is there anything we can do to combat the antecedents she mentioned? What are your thoughts on "the customer is always right" with regard to incivility? How far should organizations go to protect their front facing workers? Christine and Alison give several examples of organizations putting measures in place to protect their employees, which example stood out to you? Is there anything you feel could be effectively implemented at your own organization? Podcast takeaways: -Particularly bad in healthcare. -Suggested we need to revisit the customer is always right and maybe tweak that a bit. -Standard of conduct for customers or patients or post signage about conduct up front. -Training for employees on how to intervene. Some comfort in knowing there's a plan in place.

Children's Committee – Barb Saunders

Meeting Date: 4/12/24 10:00 am-11:30 am Next Meeting Date: 6/14/2024 10:00-11:30 am

Co-Chairs: ***Lisa Peterson-Lizun*** *(Allegheny Children's Initiative) and* ***Barb Saunders*** *(UPMC)*

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Participating Members: Susan Stewart-Bayne, Sharon Campbell, Katilyn Campbell, Laura Haile, Allyson Paracat Dixon, Amy Yosko, Bethany Douglas, Tammy Marsico, Barb Saunders, Krista Lion, Alicia Logue, Nathan Omasta, Aaron Libman, Lori Grubs, Jessica Speer, Rhonda Sullivan

Agenda Items	Discussion
Welcome	Committee members and guests introduced themselves
RCPA Children's Committee Updates	Updates, Discussion & Collaboration from Jim Sharp, Chief Operations Officer, RCPA - see notes sent by Jim
Advocacy Opportunities	Conversation with Stuart Fisk and Renee Patten
Provider Updates & Announcements	See announcement from Wesley Family Services the opening of their Autism Center for Growth
Wrap Up	Next meeting: June 14, 2024, 10-11:30 am- virtual only canceling May meeting due to conflict with STAR Conference

Conversation with Stuart Fisk-
Summary of conversation with Stuart and Renee:

Introductions- each committee member introduced themselves, their agency name, their title; Stuart and Renee introduced themselves and provided details about their past work experiences.

Overview of child services document– provided to Stuart as a reference/guide; at end of introductions, it was noted that Children's CAP Committee represents many/all levels of care. Noted that Family Focused services no longer exists.

What does Stuart see as the greatest challenge facing Child BH?

- Staffing
- Regulatory burdens that stifle creativity

Separation of physical health and behavioral health

Discussion around moving funding from block/program funded to Medicaid to allow funding for creative programming. Advocated for Value Based or Alternative Payment versus fee-for-service model.

Committee stated that we are eager to partner with OBH- advocated to be at the table when decisions are made.

Discussion around the uniqueness of child services and the amount of stakeholders that are involved in providing services to children and youth (highlighting that collaboration is often un- or underfunded).

Discussion regarding workforce and the impact of losing clinicians to private practice.

Renee provided the following updates to the committee:

DHS focus on staff recruitment and retainment- BH Fellows program

DAS RFP was awarded to Southwood who is constructing a new hospital (bed capacity of 90). DAS is expected to be 10-20 beds with length of stay between 60-90 days on current hospital site.

Mercy is working on re-opening their DAS program.

Family Based referral management trail is underway with a few FB providers volunteering to try it out.

Safety / Risk Committee- Casey Monaghan

April 12, 2024

Attendees:

Gretchen Kelly, PLEA
Tamara Caldwell, Family Links
Sue Coyle, Chartiers
Lynette Deaver, Children's Institute
Brian Roche, Mainstay
Keith Barnhart, Emmaus
Casey Monaghan, Devereux/TCV

General Discussion:

1. Decided to ask the group at the general meeting for the best day/time for WFS to provide their safety program overview covering how they complete assessments, tool/resources, drilling, collaboration. The committee would like to get as many people as possible in CAP to benefit from this information sharing.

2. Extensive discussion on vehicle & driver safety. Among the bigger problems seems to overall be accountability systems, more specifically: unexplained damages; non-reporting; premature wear and tear; management of driver behavior; lack of oversight by supervisors; under-utilization of monitoring systems such as GPS. All have vehicle safety policy, motor vehicle record review systems, and driver safety training, yet we all still have problems. Solutions discussed:
    - Re-train and re-credential annually
    - Systems like picking up a rental car to document existing damage on a vehicle diagram and the previous driver(s) gets investigated for any new damages that had not been reported.
    - Drug testing and MVR review following every vehicle incident.
    - GPS systems when utilized; vendors used for this are Verizon, Azuga, and Geotab. This service may reduce insurance premiums in some cases.
    - Video recording systems not just covering the road but also covering the interior of the vehicle; this will be a topic for further discussion and exploration.
    - Incentive programs (lunch, gift cards) for no incidents or new damages to vehicles. Check with insurance brokers, they may participate and provide gift cards accordingly.

Next Meeting: May 10th, 9AM via Teams.
Minutes prepared by: Casey Monaghan

Compliance Committee- Shayna Sokol
4/11/2024
Attendees: Kim W (HASO), Jerry C, Barb N, Emily, Jodee, Kelli

Agency 1: Pending DA FWA Audit, records submitted 6 weeks ago with no feedback. Recent uptick in resignations in the several programs. Cost shift in AC to CCBH have resulted in increased expectations is a noted factor in exit interviews.

Agency 2: No recent audits for EISC, Beaver SCU had verification from state, no feedback yet. Significant staffing issues/concerns, currently offering PT and a signing bonus to attempt to recruit. Rate study recently completed by the state, in partnership with providers. Working with ACEI to partner in strategies to alleviate stressors due to staffing vacancies.

Agency 3: Recent provider qualification for vocational and IDD. Recent citation with one office for on-site doctor time. Attempting to pool resources to address this need. SCA audit in March, results pending. Increasing education on issues identified in audit, including ROIs. Changing records to Credible and obtaining resources. Licensing focus seems to be on ROI. Additional distant county audit in May, requesting information related to fiscal policy and procedure manual and internal reporting procedures. Agency has submitted questions related to this experience to clarify needs of the auditor to best tend to the request. Increasing mock audits at some locations and completing quality record reviews with CCBH in CPHP and annual licensing for IBHS.

Agency 4: Recent licensing with ODP for res/life sharing; concentrated on functional assessment matching the ISP. Attempting to wave 50% on-site psychiatric requirement. Follow-up because it was taking an extended period of time to receive a response, with the county requesting a more concrete plan for addressing non-compliance. FWA self-report for CCBH pending, no issues or concerns. Issues with Tx plans expiring, and services still being rendered, utilizing record system resources and consultation to address. Recent CCBH Quality Review with BSC program, POC needed to address deficiencies. Pending BSC audit. Agency looking to implement site/mobile PR program.

Agency 5: BSC program completed a quality audit recently, resulting in an improvement plan related to monitoring of allergies, suicide care mgt. plan, and evidence of care coordination with PCP. Annual licensing is pending at the end of the month.

Agency 6: Recent licensing and quality visits in PR, IBHS, FC, and PHP programs. Discussed citations related to clearances, CPSL training, and treatment plan signatures.

- Self-Audits: Providers are being asked to complete self-audits following quality monitoring with CCBH.
- Quality Assurance Plans: Discussed more intensive review of quality assurance components of licensing including annual quality review plans, public availability.
- Allegheny County incidents and RCAs: Discussed the elimination of RCAs and pending changes to the AC incident report processes.
- CCBH/Carelon Incidents: Group reminded to review the provider alert from January and Q3 newsletter related to IR with MCOs.

Human Resources Committee- Sherry Brill

HR CAP Meeting Notes 4/30/2024

Members present- Sherry Brill- Chartiers Center- Committee Chair, Doug Clewett- Easter Seals, Judy Muller- Transitional Services, Alana Delaney- Family Resources, Eric Ziegler- Residential Care Resources, Willette Walker- Mainstay Life Services, and Lauren Wright- Children's Institute

1) **FLSA Overtime Ruling- the** US department of Labor (DOL) issued a final version of the ruling that will increase the salary threshold for the FLSA white-collar exemption from overtime pay. This is another unfunded mandate...We discussed how agencies plan to handle this with their staff. Most said they may to fine for July but will have to eventually transition those workers to hourly instead of salary workers. This can turn out to be a difficult conversation to have and may cause retention issues amongst organizations. One organization said almost 90% of their workforce is hourly however, when they made the transition years ago it was challenging. Although as therapist or case manager with the documentation they are really tracking almost everything they do currently. That is one way to spin that to the employees who may feel like they will no longer be looked on as professionals.

2) **Health Insurance Renewals**- Of the group most have received their insurance renewals, and they have all come back between 19-45% all with various insurance providers. We discussed alternative options such as level funding, self-funding and ICHRA. with Self-funding there is a concern around compliance and the requirements that would need to be met for employers. Highmark seemed to do the most negotiating and even brought one agency down to 0% that originally came back at 15%. Reasons behind the increases ranged from not having enough dependents on the insurance, to large shock claims, to high-cost prescriptions. One agency moved to a very high deductible (which is a lower premium cost) and funded a substantial portion of the deductible.
3) **Performance Based Contracting and getting prepared for Credentialling with staff from ODP- "**Another Unfunded Mandate" One agency is piloting a program with staff to have a tiered incentive for earning badges. After they earn their first badge, they get a salary increase, and at the other two levels they get a one-time amount. It is not clear if the type of certification matters. Some agencies are using NADSP or NADD certification. It has not been clear in several meetings. Organizations need to submit their plan by fall but the question remains to be clarified what qualifies for the certification requirement for DSPs.
4) **Recruiting-** some of have seen an uptick in applications and new hires, although the overall workforce shortage is still prevalent amongst the group. Since the large layoffs at UPMC, some wonder if we will see an increase in eligible applicants. Some have seen increase due to employee referral programs or travel allowance for those who struggle with transportation.

Next meeting is Tuesday May 28th, 2024, at 1pm

The next meeting is scheduled for May 10, 2024- location- Goodwill Offices- Lawrenceville, In Person Only.

Respectfully submitted,
Kate Pompa