DHS Responses to Public Comments Regarding – Behavioral Health Counselling Code Rate Increase SPAs

Heather Maino, LCSW

Comment: I am a long time mental health professional in the State of Arkansas and have spent most of my career working in Community Mental Health. I have seen many changes over the last 30 years, and I'm highly concerned about what I'm seeing proposed as rate cuts to Group Counseling services. In my current role, I don't provide group counseling services, but I know enough about our Seriously Mentally Ill population in the State of Arkansas to know that our Rehab Day Programs across the State will be dramatically impacted by such cuts. These programs are a lifeline of support and stability, keeping a large population of our SMI citizens living successfully within the community.

In my own experience, I know that Rehab Day programs rely on group counseling rates to subsidize the whole of their programming because revenue from the "Rehab Day Service" billing is not enough to sustain such efforts. While I know that this is a "Medicaid" decision - not a PASSE decision, I'm concerned that Arkansas PASSE's will treat the Medicaid rate cut as the standard for their own contracting. They often treat the Medicaid rate as the "ceiling" not the "floor" for their own decision making and providers have little room for leveraging alternative rates with them.

If Rehab Day programs become unsustainable and cease operation, the cost of increased hospitalizations, increased emergency room visits, and increased demand of the legal system to care for mental health needs will rise exponentially. These systems are not equipped or expansive enough within our State to manage that burden.

I'm asking for sincere consideration to protect our SMI consumers. Please do not act hastily without adequate protections in place for them.

Response: Adult Day Rehabilitation is one of many services that are in place to maintain adults with Serious Mental Illness (SMI) in home and community settings and is a home and community based service (HCBS). These HCBS should be used in conjunction with professional services such as individual counseling and group counseling as interventions to provide appropriate treatment to individuals with SMI. Some of the HCBS can be provided in a group setting. The providers of these services will have continuing discussions with PASSEs to determine the best combination of professional and HCBS.

Joel Landreneau

Executive Director

Arkansas Council for Behavior Health

Comment: I am Joel Landreneau. I am Executive Director of the Arkansas Council for Behavioral Health and the Council has some comment to make about the rule proposal. First, the Council notes that the stated goal of the rule amendments are to provide good quality, easily accessible counseling services to eliminate or reduce the need for higher cost institutional care, and the Council believes that some of the proposed changes accomplish that, and the Council believes that other changes run a completely counter to that stated goal. For one thing, the PCP referral requirement was never a good idea. So, it is obviously a good idea to get rid of it. The PCP referral was never anything more than a procedural hurdle that acted as a barrier to access to care. We at the Council had asked for the removal of it for adults and were pleased to see that the Department has seemed fit to get rid of it for all behavioral health clients, and we believe that this is a positive change. The individual and marital and family counseling rates were a concern to us as well. Back in May the Council had the pleasure of hosting an in person meeting with Secretary Putnam, and with Assistant Director Janet Mann and Paula Stone, and they at that time assured the Council that the Department was working on a complete overhaul of Medicaid rates and a search for service gaps. They called it the Medicaid sustainability review process. Our observation at this date, November 1st, 2023, is that that process has only barely begun, if it has begun. And the plan was to have the process completed by the end of the year. The promise there was to look at the service gaps and to plug those gaps with newly designed services to make sure that there was a seamless continuum of care. The Council doesn't believe that has happened. But at the very least, we were gratified to see the temporary disaster SPA rates for individual and marital and family being made permanent. That was a concern. With the NSRP not advancing at the initial pace of change, it was a concern that that might revert back to the old rates, and it is gratifying to see that that is not the case. However, we don't share our enthusiasm for the reduction in the group therapy rates. And here's why. It is true that group therapy rates are out of line with group therapy rates with Medicare, and the adjustment of it to 100% of Medicare does align it with Medicare. The problem with this approach is that it doesn't take into consideration the role the group therapy plays in our service continuum. It's been our observation that rates tend to get looked at in isolation for that particular service and there's no evidence that I can see that there's been a consideration for the role that the rate plays in the entire service continuum. We are concerned that there are chronically, mentally ill adults who need to be seen multiple times a week who attend day rehab programs for whom this group therapy rate is an integral part. And it's an integral part of making those services economical to provide. Our concern is that there are programs that simply won't continue that programing if this rate cut is put into effect. Now, I understand that this is just a rate change for the behavioral services manual. This is tier one. The problem though, is that we know that the Passes tend to look at the Medicaid rate, not only as the floor, but also as the ceiling. And our concern is that there are tier 2 and tier 3 clients who will not be seen, because these programs won't be able to continue because the PASSES will mirror the rate in the fee schedule that's proposed here. We believe that's gonna be a harm to those clients' long term and it's going to result in more institutional care because a lot of these people are hanging on a thread. We've had this conversation with DHS before, and I think DHS has acknowledged that there is a service gap between the residential services in a level two therapeutic community and just being out on your own and that there's a middle ground where there's really nothing there for people and this fulfills that role. And we've talked about maybe a level 3 therapeutic community or act teams, or some other intervening force that's between residential and on your own. But without that in place it seems unwise to the Council to get rid of the stop gap measure, that you have to meet that need without proposing something and implementing something to take its place. We believe, therefore, that the group therapy rate is cut is premature without those

services to be put into place, to fulfill the function it is currently fulfilling. And we would ask that DHS delay that rate or at the very least bear upon the PASSEs to not pass it on for the tier 2 and tier 3 clients. We think that access to care and the prevention of institutionalized care would require that we provide services in this space in the continuum without disrupting what's happening at the present time. Thank you.

Response: The state completed the rate study for outpatient counseling and proposed the new rate setting methodology using a percentage of Medicare in 2022. AR Medicaid raised the rates for individual and family counseling to 80% of Medicare in fall of 2022 through a disaster state plan amendment (SPA). At that time providers were informed that group counseling rates would use the same rate setting methodology with a decrease in group rates to 100% of the Medicare rate but did not submit the decrease using a disaster SPA. This rule makes permanent the increase and enacts the decrease. The providers of services for Medicaid beneficiaries with Serious Mental Illness will have continuing discussions with PASSEs to determine the best combination of professional and HCBS to support them in home and community settings.

Joel Landreneau

On behalf of the Arkansas Council for Behavior Health

Comment: On behalf of the Arkansas Council for Behavioral Health, I thank you for the opportunity to comment on the Department of Human Services' proposed rule, "Outpatient Behavioral Health Counseling Services and Rates (Rule 219). The Arkansas Council's members applaud some of the changes contained in the proposed rule promulgation. First, the Council applauds the abrogation of the requirement to obtain a referral from a primary care physician in order to allow Medicaid beneficiaries to access outpatient behavioral health services. This procedural barrier to care was implemented in 2018, and it was never necessary, and it was never an effective cost containment measure. It was never anything more than a barrier to care, another hoop through which beneficiaries must jump in order to access needed services, and one that very frequently delayed the onset of care delivery. Similarly, the Council welcomes the State Plan Amendment that adopts the disaster SPA rates for individual and marital/family services into the permanent State Plan. The Council had been assured by DHS that the Department was working on a complete and comprehensive review of everything Medicaid, including rates in all provider types and an examination of service gaps in behavioral health so that no portion of the Medicaid program would be amended in isolation, but that any changes would be made as part of a complete assessment of the adequacy of the full-service continuum. The Council was concerned about the expiration of those temporary rate adjustments that were set to expire 12/31/23, and the Council welcomes their adoption into the permanent state plan. The Council understands that plans change, and that DHS' plans to conduct a comprehensive review of Medicaid (which it dubbed the "Medicaid Sustainability Review Plan," or "MSRP") was overtaken by the demands DHS faced in accomplishing the completion of the Public Health Emergency unwind that was mandated by state law to be completed in six months. Consequently, it comes as no surprise to the Council that MSRP remains in its early stages, despite earlier aspirations to complete it by 12/31/23. 2 That said, the Council reminds DHS that MSRP is

not complete, and that by DHS' own admission, there are service gaps in its behavioral health service continuum which remain unaddressed. However, rather than complete MSRP and address these gaps, DHS once again addresses rates for specific services in isolation from the larger context of the adequacy of the service continuum and proposes in this rule promulgation to reduce the rate paid for group psychotherapy by an amount that will require certain providers to reassess whether or not continuation of certain adult day rehab programs for seriously mentally ill adults is even feasible. Day Rehabilitative Services have always been a critical element in the serving of persons with serious mental illness across the state. Most, if not all, of these programs are operated by the Community Mental Health Centers who provide care to this population and help to manage their day-to-day symptoms. Without the structure of these programs, most of these members are at serious risk of decompensation, inpatient hospitalizations or arrests that force the jail staff and law enforcement to undertake the tasks of managing the symptoms of SMI adults without either the expertise or the resources to do so. While it is a critical component in the continuum of care, Day Rehab as a stand-alone service is a financial liability and is not sustainable. The current rates for group therapy fill in this gap, providing a key piece of the service puzzle that is offered alongside Day Rehab, which benefits members clinically while helping to offset the financial liability of the overall program. There are between 1,200 and 1,500 Seriously-Mentally Ill adults that attend Day Rehab programs operated by Council members. The proposed rate cut by nearly 50% will cause a substantial number of these programs to cease operations. This is the exact opposite of what DHS stated it hoped to achieve when it announced its MSRP review. Rather than review Medicaid to locate and alleviate service gaps, with this rate change, DHS will be creating a new service gap. Council members have been in discussion with DHS about ideas that can be implemented into action to address these gaps. However, the hard truth is that these ideas are only items for conversation at this point. The Council would like to see evidence-based services implemented to serve that population of SMI adults who no longer need daily residential supervision in a Level 2 Therapeutic Community, but for whom weekly individual psychotherapy is insufficient. Group therapy is part of the stop-gap measure to bridge that gap, and the Council considers it unwise in the extreme to eliminate that stop-gap before first implementing the measures that will take its place. Those measures have not advanced beyond the talking stages. The Council has been told that these proposed changes only address the Medicaid fee-for-service fee schedule, and that SMI adults served in PASSE would not be directly affected. Our five-year history in dealing with the PASSE entities would indicate that this view is incorrect. While the PASSE entities are required to treat the FFS fee schedule as a floor, they also treat it as a ceiling. We fear that closure of Day Rehab programs will result if PASSE 3 entities pass along the rate cut in group therapy, and that will result in a spike in inpatient hospitalizations, jail admissions, or both. The Council strongly urges DHS to reconsider the group therapy rate cut until a proper service continuum for SMI adults can be put into practice, and urges DHS to require the PASSEs to maintain the current rate for these services until their replacement can be implemented. The Arkansas Council appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact Joel Landreneau. Thank you for your time and consideration.

Response:

The state completed the rate study for outpatient counseling and proposed the new rate setting methodology using a percentage of Medicare in 2022, well before the beginning of the MSRP. AR Medicaid raised the rates for individual and family counseling to 80% of Medicare in fall of 2022 through a disaster state plan amendment (SPA). At that time providers were informed that group counseling rates would use the same rate setting methodology with a decrease in group rates to 100% of the Medicare rate but did not submit the decrease using a disaster SPA. This rule makes permanent the increase and enacts the decrease. The providers of services for Medicaid beneficiaries with Serious

Mental Illness will have continuing discussions with PASSEs to determine the best combination of professional and HCBS to support them in home and community settings.

Jared Sparks

For Arisa Health

Comment: Thank you for the opportunity to provide feedback about the proposed rule revisions. Arisa Health, Inc.'s comments are attached. I also sent this using the Arisa Health email address. Have a good weekend.

We appreciate the efforts DHS is undertaking to support quality behavioral health care for the citizens of Arkansas. Removing the PCP referral requirement and making permanent the individual counseling rates are positive and appreciated steps. There are questions in response to the proposed rule revisions that may outline additional areas of opportunities for provision of safe, efficient, and effective care.

Outpatient Behavioral Health Services

***Effective January 1, 2024, the following services will be adjusted to pay 100% of the 2022 non-rural rate for the state of Arkansas*.**

Group Behavioral Health Counseling

Given that Arkansas is a rural state with health care provider deserts, why is the non-rural rate being used?

In comparison to a rural rate, will the use of a non-rural rate result in a higher or lower overall level of reimbursement per behavioral health service?

Response:

The state did not use a rural differential in its analysis for outpatient behavioral health counseling services.

Is the Group Behavioral Health Counseling rate adjustment only for Tier 1 clients?

A rebasing of the group rate for PASSE clients would reduce one of the few tools available to be used in conjunction with rehabilitative day programs for adults with serious mental illness. Does DHS have another plan for this population? Similarly, this reduction will affect one of the few tools available to be used in conjunction with Therapeutic Day Treatment programs for children who are severely emotionally disturbed.

Why is Medicaid using the 2022 fee schedule when these rates are slated for 2024?

Response:

The state completed the rate study for outpatient counseling and proposed the new rate setting methodology using a percentage of Medicare in 2022. AR Medicaid raised the rates for individual and family counseling to 80% of Medicare in fall of 2022 through a disaster state plan amendment (SPA). At that time providers were informed that group counseling rates would use the same rate setting

methodology with a decrease in group rates to 100% of the Medicare rate but did not submit the decrease using a disaster SPA. This rule makes permanent the increase and enacts the decrease. The providers of services for Medicaid beneficiaries with Serious Mental Illness will have continuing discussions with PASSEs to determine the best combination of professional and HCBS to support them in home and community settings.

202.000

A.2. Group practices of Independently Licensed Practitioners can enroll directly without certification.

Why is this option being offered?

In comparison with group practices of ILPs, certified agencies typically provide services to more clients with serious mental illness and higher acuity. These agencies must also support a costly administrative burden to become certified. In acknowledgement of the increased risk and cost, certified agencies assume to provide services, why is there not a higher rate paid to certified agencies?

If, on the other hand, some ILP group practices serve some high needs clients but do not have the additional requirements of certified agencies, are there not quality of care concerns?

Response:

This was not changed in this rule.

214.3 Substance Abuse Covered Codes

…Behavioral Health Agency and Community Support System Providers Intensive and Enhanced Sites must be licensed by appropriate DHS division to provide Substance Abuse Services

The state could eliminate added cost if there was a single licensure for agencies that provide Substance Abuse Treatment and Mental Health Services. This would remove the need for two certifications with two separate expiration dates and two different annual audits.

Response

Thank you for your comment. While this is not a certification rule the state will consider this in future.

240.100 Reimbursement

A. Counseling Services

and

241.00 Fee Schedule

What are the time frames/ranges for encounter-based services such as group and individual?

Units are identified as encounters for some services such as Individual Behavioral Health Counseling. There is not an easily identified time frame per encounter. This is necessary to support appropriate billing practices and to inform external audits. The time frames in the Counseling Manual do not seem to apply to encounters, as this is “an otherwise stated” unit. The linked Counseling Services Procedure Code Table also does not provide guidance.

The National CPT Codes have a range of 16 -37 minutes for psychotherapy 90832. This is the procedure code identified in the procedure code table for the Division of Behavioral Health. We would like to confirm that Arkansas is using National CPT Code standards to define time frames for services such as 90832. What is the time frame/range of a 30-minute individual behavioral health counseling service in order to bill this service in compliance with National CPT Codes and AR behavioral health and DMS standards?

Response:

The state continues to look at the CPT codes and will provide guidance on appropriate use of these codes.