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Of Behavioral Health & Family Services Providers

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OhioMHAS CSI PRTF Rules
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Thank you for the opportunity to provide comments and feedback on the OAC Chapter 5122-41 rules to support the development and implementation of psychiatric residential treatment facilities (PRTF) in Ohio. We appreciate the collaborative efforts to build this important, intensive service needed by a youth with significant behavioral health needs and challenges.

As currently written, the rules to implement a PRTF service create an overly complex regulatory structure that imposes a significant administrative burden and is decidedly over-regulated to the point of infeasibility for businesses to operate in Ohio. As designed, the combined rule packages require compliance with three sets of regulations under OhioMHAS (certification plus dual licensure as a class one residential and PRTF); compliance with ODM rules, enrollment, and an 87-page OhioRISE PRTF program manual (guidance set outside of administrative rule); selective contracting through an RFP with Aetna/OhioRISE; state survey requirements under the authority of ODH; and national accreditation requirements. This represents nine distinct sets of rules/guidance/contracts enforced by five separate regulating authorities. We are concerned that without substantial simplification to the regulatory structure, there will be very few providers able to develop and implement this much-needed intensive service due to the complexity and cost of these requirements.

Below are our specific comments on the individual proposed rules.

MHAS Chapter 5122-41 Psychiatric Residential Treatment Facilities

<u>5122-41-01 Purpose, definitions, and general requirements.</u>

1. The definition and examples of ancillary services in (B)(1) are vague given the requirement in 5122-41-07 paragraph (F)(8) to provide at least 2 hours a day, seven days a week of this service. This unclear description of an otherwise undefined service is difficult for businesses to operationalize, ensure they are meeting the standard adequately, and jeopardizes their business by creating a risk for recoupment of payment if an auditor has a different interpretation of "ancillary services". We recommend offering more concrete examples, such as structured social activities, activities of daily living, group, or individual recreational activities, etc.
2. (B)(7) indicates a PRTF must have a Medicaid provider agreement and (C)(2) indicates a PRTF must be selected by Ohio Medicaid to provide PRTF services to Ohio Medicaid recipients. MHAS certification and licensure requirements have historically been payer agnostic. Although PRTF is a specific Medicaid service, this gives the impression that OhioMHAS will only certify PRTFs for Ohio Medicaid and will likely cause confusion for providers operating as PRTFs in other states or choosing to service youth with other payers. This also could cause conflict for future parity efforts related to commercial insurance plans covering these services. We strongly recommend (B)(7) and (C)(2) be removed from this rule and referenced in the ODM rule 5160-59-03.6.
3. Paragraph (C)(3) requires certification with the Ohio Department of Health (ODH), however, does not give any specific information or details on what this certification survey entails. The federal

code referenced does not outline the specific requirements or details necessary to achieve this certification. We have requested additional information on what these specific ODH or federal requirements will entail and questioned whether they are duplicative of the requirements outlined in OAC Chapter 5122-41; however, no further information has been provided by OhioMHAS. Businesses interested in providing this service must have adequate information to ensure they are meeting all the requirements to avoid loss of time, resources, and possibly certification. Additional details on the ODH requirements should be included in the rule language to fully inform businesses of the ODH certification requirements.

4. In (F), there are duplicative incident reporting requirements that will be administratively burdensome for businesses, adding time, complexity, and additional cost to be in compliance with this rule. A PRTF is required to follow the incident reporting requirements outlined in 5122-30-16, which requires electronic reports to be entered into the OhioMHAS Web Enabled Incident Reporting System (WEIRS) and includes the same or similar (more expansive) types of "serious occurrences". Reporting in WEIRS also results in a copy of the incident report being sent to DRO. Instead of a PRTF separately and repetitively reporting the same information to OhioMHAS, ODM, and DRO, we again recommend OhioMHAS develop an automated process for information to be shared from WEIRS with the Ohio Department of Medicaid and limit the additional reporting to only notifying the CMS regional office of a resident death.

5122-41-02 Psychiatric residential treatment facility model

1. The requirement for "an Ohio department of Medicaid third-party assessor" discussed in (C)(2) of this rule is unclear. This could be interpreted to mean any professional with assessment in their scope of practice, causing confusion for organizations looking to implement these criteria. We assume this is intended to be a CANS assessor. If the language in (C)(2) is intended to indicate a third-party CANS assessor, we recommend this be made explicitly clear, by adding "CANS" into (C)(2) of this rule.
2. (C)(13) includes availability of post discharge transition support – which is agreeable but must also be specifically and intentionally included as a covered service post discharge service when provided by the PRTF and no longer bundled in the per diem rate. Currently, there is no mechanism in the ODM rules for a PRTF to be compensated for this mandatory service component. Post discharge support will vary widely by patient and businesses should not be expected to provide ongoing services at no charge, this has potential to impact staff availability and revenue.
3. Paragraph (E) outlines trauma-informed care requirements. However, trauma competencies are also outlined in paragraph (B)(2) of 5122-41-08. The rules would be improved if the trauma-informed model and training requirements were located in one rule rather than spread across multiple rules and sections. As drafted, it creates compliance risk for businesses due to complexity that can be simplified.

5122-41-03 PRTF admission criteria, admissions, transitions, and discharges

1. The title of the rule includes transitions; however, the rule only discusses admission and discharge criteria. We would also note, the OhioRISE PRTF program manual, while intended to be guidance, also describes continued stay criteria which is not currently part of the rule structure. We recommend clarifying the rule title and adding language around transitions and continued stay criteria, which should be determined by the PRTF program.
2. As presented, (A)(3) indicates that programs may define admission criteria that includes the behaviors or conditions that will be treated by the PRTF and can be interpreted to imply this will "require" inclusion of treating aggressive disorders. Is this an accurate interpretation? We would note the OhioRISE program manual, while intended to be guidance, indicates that a sole

Disruptive Behavioral diagnosis (i.e., Oppositional Defiant Disorder) would be exclusionary for admission. Further, the PRTF program manual indicates that any youth exhibiting behaviors at imminent risk of harm to self or others are also exclusionary. When taken together, the rules and program guidance are sending mixed messages about how programs are expected to address aggressive or harmful behavior. Businesses seeking to develop this program need clear program standards particularly if the intent is to require organizations to accept any youth that meets the admission criteria. Clarification is warranted.

Further, the rule does not adequately address any additional specifications for admission when a youth is presenting with co-occurring MH and IDD conditions in (A). Yet the ODM rule and OhioRISE program manual call out reimbursement difference and add substantive additional program requirements for admission and exclusions specifically for co-occurring MH/IDD condition. If the Departments intend to include this level of specificity for payment and program design for contracting purposes, then it would need to be addressed in this rule that governs the admission and discharge. Significant clarification is needed, and we urge the Departments to provide maximum flexibility to treatment programs to clearly define the admission and discharge criteria.

3. In paragraph (D), we recommend aligning the timeframe for temporary leave with the ODM rule 5160-59-03.6, which is currently to up to three days. Although OhioMHAS does not regulate reimbursement for services, these requirements will impact providers by setting an expectation that businesses delivering care make available two additional days of unreimbursed temporary leave.

   Additionally, we understand (D) is an attempt to define a "no eject" policy for discharge outside of a youth's age, parental/guardian withdraw or transfer request, or "completion of successful treatment". We continue to struggle with how successful treatment will be defined and again point to the lengthy description of "discharge criteria" in the OhioRISE PRTF Program Manual. As a business, providers need clearly defined expectations to define clinical program standards, comply with these regulations, and obtain reimbursement. Additional clarification of "completion of successful treatment" is necessary in this rule.

<u>5122-41-06 Staffing, staffing qualifications, and staff ratios</u>

1. Generally speaking, the staffing requirements described in this rule, and specifically those noted below, are most commonly cited by our members as the factor that will prevent most BH businesses from developing PRTF programs. We appreciate that the Departments are attempting to align this rule with the hospital in-patient rules, but CMS regulations do offer some flexibility, particularly for nursing requirements.
2. In (E), we have concerns with requiring a 24-hour RN, PA, or APN on-site due to workforce shortages and demands in other healthcare sectors. Adding PAs and APNs to the list of those that may provide coverage is not a meaningful solution and is wildly cost prohibitive. Finding pediatric nurses, physician assistants, or advance practice nurses willing to work with our most intensive youth, particularly aggressive and IDD youth round the clock is difficult in any labor market, but with the workforce shortage of nurses, it is the number one issue that will prevent development of this service. Further, as most BH businesses now utilize electronic health records, including e-prescribing, we believe physicians or APNs that make medication orders would routinely enter a medication change order directly into the youth's medical record. Both RNs and LPNs may implement documented written orders removing the stated reason for

requiring and RN on site 24 hours per day, which is to receive a verbal order. We strongly recommend reducing RN coverage to usual waking hours (i.e., 8AM – 10PM), and relaxing the rule to allow the PRTF to utilize LPNs during sleeping hours Without changes to this staffing requirement, businesses will have extreme difficulty with initial hiring and maintaining nursing staff for this program, limiting options for service development and delivery.

3. Further, the staff to patient ratio requirements outlined in (E) are not feasible given the 24-hour coverage, non-traditional hours, and low wages envisioned by the ODM actuary. This offers no flexibility to tailor staffing to meet the needs of the youth in the program or adjust when acuity may be less.
4. In (G), we understand the rule indicates the PRTF staff must remain specifically assigned to the PRTF and cannot be shared with other residential facilities or outpatient programs. However, the rule is unclear as to whether these staffing requirements will be rigidly applied to each certified address, location, unit, or cottage. We would like additional clarification on how (G) applies when a business may have multiple PRTF locations, units or "cottages" at the same address, campus, or even within a short drive. For example, if a business has 3 PRTF units or cottages, could the business share staff assigned to deliver PRFT services across the 3 PRTF cottages or units? Or, does this rule imply that each cottage or unit will have the meet the staffing requirements of this rule for each individual cottage or unit and there is no flexibility to deploy PRTF outside of the unit or cottage to which they are assigned? Businesses need clarification on the amount of staff that will be needed and if there is any flexibility to share positions across multiple PRTF locations, units, or cottages. We urge OhioMHAS to permit flexibility within the PRTF services regardless of the location to support cross-coverage with staff trained to deliver this level of care. Otherwise, businesses will see added personnel costs as well as costs to support recruitment, retention, and training and access could be limited if cross-coverage scenarios are unavailable.
5. Given the extremely limited availability of psychiatrists and child psychiatrists, we remain concerned that the requirement outlined in (I) of on-call capacity at all times will be unattainable. Child and adolescent IP units have closed due to lack of psychiatrists willing to serve in on call capacity. Allowing a psychiatric CNS/CNP to serve in this capacity would be a welcome addition and alternative.

<u>5122-41-07 Individual plan of care and services</u>

1. In (D)(3), we continue to encourage the Department to seek CMS approval to allow use of psychiatric CNS/CNPs to meet the medical oversight requirements. It's unfortunate that this section of the federal code has not been updated to reflect the available workforce and will create significant staffing challenges given the shortages of child psychiatrists and psychiatrists. OhioMHAS can support businesses in developing this level of care by seeking a waiver or approval to recognize CNS/CNPs
2. In (F)(1), further clarification of what specifically is meant by "prescriber under <u>the direction of</u> a physician or other practitioner with prescriber authority" is needed. As drafted, it is unclear how this to be interpreted. Is this a Physician's Assistant? Is this meant to reference a Nurse Practitioner? NPs practice under a collaborative agreement, not under the direction or direct supervision of a physician. Does this require direct supervision as defined by ODM? Or will the last part of that phrase "OR other practitioner with prescriber authority" permit the use of NPs. We appreciate the efforts to expand this here and want to make sure the flexibility is available to use NPs in particular. However, the language must be clear so businesses can ensure their practices follow the requirements of the program and do not impact their ability to be reimbursed for services.

3. We continue to have concerns with the prescribed frequency of face-to-face consultation with a psychiatrist of at least 15 minutes each week outlined in (F)(1). A previous version of the rule required a visit at least every 14 days or more frequently as clinically needed, which is more appropriate given the potential variance of clinical needs in this population. Again, given the well-documented workforce shortages and other medical oversight in this setting, having more flexibility to respond to patient needs, particularly for medically stable patients, is necessary and allows for true individualized care. Further, these prescriptive requirements may not meet medical necessity for the service, thus ineligible for reimbursement, and should be based on the needs of the patient. Requiring businesses to provide services that may not be medically necessary puts the organization in a position to violate the requirements outlined in 5160-1-01, which apply to all Medicaid programs and paragraph (E) of 5160-59-03.6, which requires medically necessary PRTF services.
4. Overall, the requirements in paragraph (F) are overly prescriptive and would be costly to implement and administer While all these services are necessary, the detailed requirements regarding a specific number of hours of each is not likely to meet the individualized needs of each child in a PRTF and again may be in conflict with 5160-1-01 and 5160-59-03.6. We recommend considering an approach requiring a total number of hours of services over the course of the week with a portion of those hours being comprised of an array of several specific services. This will allow organizations to better meet the needs of each individual in the program, allow for transition planning to lower levels of care and service delivery, and maintain compliance with OhioMHAS and ODM requirements, and minimize risk of organizations jeopardizing reimbursement. These rules are overly bureaucratic, costly to implement, and are not business friendly. A more measured approach that grants businesses some discretion to administer the program and focus on health outcomes would better serve all stakeholders.

<u>5122-41-08 Staff training</u>

1. The changes made in (B)(1) requiring training prior to working with youth in the PRTF as opposed to the previous rule language which required these trainings within 30 days of hire will have an impact on businesses' ability to adequately staff and provide services. This will limit a program's ability to onboard staff and organizations will continue to lose staff to other employers where they may be able to start immediately. We recommend aligning the language in (B)(1) with the language in paragraph (D), which requires training to be completed within 30 days after hire.

Finally, we strongly recommend OhioMHAS incorporate the proposed seclusion and restraint rules (OAC 5122-26-16 and 16.1) which are drafted to meet the CMS requirements for PRTF be folded into Chapter 5122-41 and restore those rules to their current reading. That would allow Ohio to comply with the CMS requirements of seclusion and restraint for PRTF, which is an inpatient level of care, without overregulating the standard of care for seclusion and restraint for all lower levels of care.

Thank you for the opportunity to share these detailed comments. We share the goal of successful implementation of PRTF services within the continuum of care for children and youth. We appreciate the collaborative effort on these rules and the consideration of our previous comments throughout the drafting process. We understand this service model has become increasingly complex and is challenged by the workforce shortage that will remain for several years into the future. These services are imperative for youth with significant behavioral health challenges to remain close to home and more readily transition back to their community. We look forward to continuing our collaboration to create a regulatory environment that will support expansion of PRTFs in Ohio.