The Ohio Council
Of Behavioral Health & Family Services Providers

35 E. Gay Street, Suite 401
Columbus, OH 43215
614-228-0747 • www.TheOhioCouncil.org

OhioMHAS Draft PRTF Rules Comments
Teresa Lampl, LISW-S
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Thank you for the opportunity to provide comments and feedback on the draft rules to support development and implementation of PRTFs in Ohio. We look forward to continuing our collaborative efforts to expand access to new, intensive services that are intended to fill gaps in the current continuum of care that will be beneficial to youth with significant behavioral health challenges and needs.

MHAS Chapter 5122-41 Psychiatric Residential Treatment Facilities

5122-41-01 Purpose, definitions, and general requirements.

1. (D)(4) indicates when the PRTF is certifying a young person is in need of PRTF services that the certifications must be done by the team specified in 5122-41-08. However, that rule does not include criteria for the team. The team is now outlined in 5122-41-07.
2. In (F), there are duplicative incident reporting requirements that will be administratively burdensome for providers. 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 reporting the same information to OhioMHAS, ODM, and DRO, we recommend the OhioMHAS develop an automated process for information to be shared from WEIRS with the Ohio Department of Medicaid and limit the additional reporting to notifying the CMS regional office of a resident death.

5122-41-02 Psychiatric residential treatment facility model

3. In (B), it may be useful to more fully define allowable mental health conditions similar to the definition used in the 1915 (c) waiver for consistency and clarification. We particularly appreciate the efforts to offer a comprehensive list of complex needs, symptoms, and behavioral challenges that will be considered as eligible for PRTF services. We would recommend adding some additional detail or clarifying criteria. As examples:
    a. In (1) are there any mental health symptoms that would be excluded or not considered "severe"? How is "severe" defined?
    b. In (3), is there a timeframe for past hospitalizations – or is this lifetime?
    c. In (8), is multiple defined as more than one? Is there a timeframe consideration? For example, if a child is placed in foster care as an infant and then returns to family and returns to foster care at age 12 is that considered multiple out of home placements?
    d. Will admission be based on imminent risk of harm to self or others or solely the criteria defined in (B)?
4. We appreciate the changes/removal of the previous 5122-41-03 Certificate of Individual Need for Services rule. It appears the requirement for an independent third-party assessor discussed in (C)(2) of 5122-41-02 needs to be revised to align with the updated

requirements in 5122-41-01 (D)(4). We recommend changing (C)(2) to "Eligibility and appropriateness for PRTF service is determined in accordance with 5122-41-01."

5. In (C)(5), how is "time-limited with short lengths of stay" defined? In a managed care environment, this is usually less than 14 days and there is concern this creates unintended risk of early discharge rather than the stated goal of allowing the young person to successfully transition to community, which is equally subjective.
6. How does (C)(9) intersect with (C)(2)? Will this allow the PRTF to complete all necessary follow-up CANS? We would support that given the intensity of care and team-based process that includes family or caregiver participation.
7. (C)(11) includes availability of post discharge transition support – which is agreeable but must also be specifically and intentionally included as a covered service post discharge when provided by the PRTF and no longer bundled in the rate.
8. In (C)(12) does "PI" mean performance improvement? If so it would be better to spell it out.

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

9. The discharge requirement in (D) as written is in conflict with other rules (outlined below), is subjective, and is not aligned with standard medical practices for inpatient levels of care. What is the definition of "completion of successful treatment"? If the client has unmet goals, but no longer meets medical necessity criteria will PRFT services be expected to continue, and will they be reimbursed? Does this mean the PRTF has full and definitive clinical authority to determine achievement of successful treatment, and this is not conditioned on the utilization management practices or review by the OhioRISE plan or another payer? Additionally, does OhioMHAS assure and commit to providing reimbursement for any and all days where the youth leave the PRFT for admission to a hospital? Otherwise, this creates an undue burden and capacity challenge for providers. Although OhioMHAS does not regulate reimbursement for services, these requirements will impact providers ability to be paid for services and limit PRTF capacity as currently written.
10. The requirement in (D) that a PRTF will not initiate discharge of a young person prior to "completion of successful treatment" is in conflict with the definition of discharge in paragraph (A)(4) of 5122-41-01.

5122-41-04 Youth and family engagement

11. We appreciate the changes that were made to this rule. Thank you for considering and incorporating our previous comments.

5122-41-05 Care coordination, transition planning, and continuity of care

12. We appreciate the changes that were made to this rule. Thank you for considering and incorporating our previous comments.

5122-41-06 Staffing, staffing qualifications, and staff ratios

13. In (E), we have concerns with requiring 24- hour RN on-site and on-duty due to workforce challenges and demands. We would support RN coverage during usual waking hours (i.e 8AM – 10PM), with 24-hour RN accessibility. Having the ability to utilize LPNs during sleep hours would equally be preferable with RN accessibility. If there is a CMS requirement for 24-hour on-site RN services, please share that specific citation.
14. Given the extremely limited availability of psychiatrists and child psychiatrists, we are deeply concerned the requirement outlined in (J) of on-call capacity at all times will be unattainable. Child and adolescent IP units have closed due to lack of psychiatrist willing to

serve in on call capacity. Allowing a psychiatric CNS/CNP to serve in this capacity would be a possible alternative.

5122-41-07 Individual plan of care and services

15. 42 CFR § 441.154 Active treatment provides for development and implementation of a care plan within 14 days. As such, we strongly recommend (A)(1) be amended to align with the CMS requirement of within 14 days rather than 72 hours.
16. In (D)(3), we encourage the Department to seek approval to allow use of psychiatric CNS/CNPs to meet the medical oversight requirements. It's frustrating this section of federal code has not been updated to reflect the available workforce and will create significant staffing challenges.
17. (F)(3)(a) and (b) make reference to a "clinical psychologist" and then (F)(4)(c) references a licensed psychologist. In Ohio, there isn't a professional licensure for master's level trained psychologist or a definition of "clinical psychologist". This section needs aligned with Ohio's psychology licensure definitions for clarity.
18. Given the workforce shortage, we recommend changing the language in (E)(2) and (F)(1) from "other qualified physician" to "other qualified independent medical practitioner" to allow for a psychiatric CNS/CNP to complete this requirement.
19. What is the rationale for increasing the prescribed frequency of face-to-face consultation with a psychiatrist of at least 15 minutes each week from the previous version of the rule that required a visit at least every 14 day or more frequently is clinically needed? Again, given the well documented workforce shortages and other medical oversight, having more flexibility to respond to patient needs, particularly for medically stable patients would be appreciated. Prescriptive requirements may not meet medical necessity for the service.
20. Paragraphs (F)(7) and (G)(7) include "ancillary services", but there is no definition or example of such services. This section would benefit from inclusion of more detail on what is intended by ancillary services or add a definition in 5122-41-01.

5122-41-08 Staff training

21. While we appreciate the effort to support standardization of training programs and curriculum, this level of specificity and detail will result in unintended limitations and/or challenges as curriculum's change or newer more contemporary and comparable programs become available.

5122-41-09 Data, outcomes, and performance improvement

22. This rule could be reduced to the initial statement in (A) and end after the second "performance improvement" phrase.
23. Further discussion should be considered to better align data and outcomes with the OhioRISE data and metrics to standardize assessment of health outcomes and value of PRTF services.

Thank you for the opportunity to share these detailed comments. As we await the corresponding PRTF draft rules from the Ohio Department of Medicaid, we may have further comments on the OhioMHAS draft rules pending review of the ODM PRFT rules. We look forward to further discussion and collaboration to support successful development and implementation of PRTFs.